FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** COMPLETE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) // F 000 **Initial Comments** F 000 An unannounced Medicare/Medicaid standard Preparation and/or execution of the Plan survey and biennial State Licensure Inspection of Correction does not constitute was conducted 3/1/16 through 3/4/16. admission or agreement of the provider Corrections are required for compliance with 42 of the truth of the facts alleged or conclusions set forth in the statement of CFR Part 483 Federal Long Term Care deficiencies. The Plan of Correction is requirements. The Life Safety Code survey/report prepared and/or executed solely because will follow. Two complaints were investigated. it is required by the provision of Federal and State law. The census in this 120 certified bed facility was This plan of correction is the facility's 115 at the time of the survey. The survey sample credible allegation of compliance. consisted of 26 current Resident reviews (Residents #1- #20, #25-28, and #30-31) and 5 closed record reviews (Residents #21-24 and 12 VAC 5-371-150 Resident Rights #29). 12 VAC 5-371-150 (C,D,E) Cross Reference to F-156 F 001 Non Compliance F 001 The facility was out of compliance with the 12 VAC 5-371-110 Management and administration following state licensure requirements: 12 VAC 5-371-110 (B,2,3,) Cross This RULE: is not met as evidenced by: Reference to F-225 The facility was not in compliance with the following Virginia Rules and Regulations for the 12 VAC 5-371-220 Nursing Services Licensure of Nursing Facilities: 12 VAC 5-371-220 (D, E) Cross 12 VAC 5-371-150 Resident Rights Reference to F-241 12 VAC 5-371-150 (C,D,E) Cross Reference to F-156 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (A) Cross Reference 12 VAC 5-371-220 (H) Cross Reference to F-157 to F-246 12 VAC 5-371-110 Management and 12 VAC 5-371 Maintenance and administration Housekeeping 12 VAC 5-371-110 (B.2,3,) Cross Reference to

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12 VAC 5-371-220(D,E) Cross Reference to F-241

12 VAC 5-371-220 Nursing services

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F-225

12 VAC 5-371 (A) Cross Reference/to-

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(X6) DATE

F-252

If continuation sheet 1 of 5

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING l₁ 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER-BATTLEFIELD PARK 250 FLANK ROAD PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 001 Continued From Page 1 F 001 12 VAC 5-371-250 Resident 12 VAC 5-371-220 Nursing services Assessment and Care Plan 12 VAC 5-371-220(A) Cross Reference to F-246 12 VAC 5-371-250 (A,D,E) Cross Reference to F-278 12 VAC 5-371-370 Maintenance and Housekeeping 12 VAC 5-371-370 (A) Cross Reference to F-252 12 VAC 5-371-250 Resident Assessment and Care Plan 12 VAC 5-371-250 Resident Assessment and 12 VAC 5-371-250 (C,F,H,I) Cross Care Plan Reference to F280 12 VAC 5-371-250 (A,D, E) Cross Reference to F-278 12 VAC 5-371-200 Nursing Director 12 VAC 5-371-250 Resident Assessment and 12 VAC 5-371-200 (B) Cross Reference Care Plan to F-281 12 VAC 5-371-250(C, F, H, I) Cross Reference to F-280 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-200 Nursing Director 12 VAC 5-371-220 (A.B) Cross 12 VAC 5-371-200 (B) Cross Reference to F-281 Reference to F-309 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(A,B) Cross Reference to F-309 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (A) Cross Reference 12 VAC 5-371-220 Nursing Services to F313 12 VAC 5-371-220(A) Cross Reference to F-313 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220(A,B) Cross Reference to F-323 12 VAC 5-371-220 (A,B) Cross Reference to F 323 12 VAC 5-371-370 Maintenance and Housekeeping 12VAC 5-371-370 (A) Cross Reference to F-323 12 VAC 5-371 Maintenance and Housekeeping

STATE FORM

12 VAC 5-371-220 Nursing Services

12 VAC 5-371-220 Nursing Services

12 VAC 5-371-110 Management and

12 VAC 5-371-220(D) Cross Reference to F-328

12 VAC 5-371-220(A) Cross Reference to F-329

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F-323

12 VAC 5-371 (A) Cross Reference to

If continuation sheet 2 of 5

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AND PLAN O	F CORRECTION	IDENTIFICATION NU	JMBER:		NG	(X3) DATE SURVEY COMPLETED
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F 001	Continued From Pa	ge 2		F 001	12 VAC 5-371-220 Nursing S	
	Administration 12 VAC 5-371-110 (J) Cross Reference	to F-334		12 VAC 5-371-220 (D) Cross to F-328	Reference
	12VAC5-371-220. Nursing services. 12VAC5-371-220-(B) Cross Reference to F-369 12 VAC 5-371-300 Pharmaceutical Services 12 VAC 5-371-300(B) Cross Reference to F-425 12 VAC 5-371-180 Infection Control 12 VAC 5-371-180(A, B, C.1) Cross Reference to				12 VAC 5-371-220 Nursing S	ervices
				· ke	12 VAC 5-371-220 (A) Cross to F-329	Reference
					12 VAC 5-371-110 Maintenand Administration	i
	F-441			•	12 VAC 5-371-110 (J) Cross R to F-334	eference
	12VAC5-371-370. M 12VAC5-371-370.(A	laintenance and hou) Cross reference to	sekeeping 456		12 VAC 5-371-220 Nursing Ser	Vices
ļ	12 VAC 5-371-360 (12 VAC 5-371-360(A F-514	12 VAC 5-371-360 Clinical Records 12 VAC 5-371-360(A, E) Cross Reference to	ce to	,	12 VAC 5-371-220 (B) Cross Ro to F-369	eference
	12 VAC 5-371-140 (a Based on facility doc		d - t - 60		12 VAC 5-371-300 Pharmaceuti Services	ŀ
	interview, the facility Employee #20 of 20 license check prior to	staff failed for one employees, to obta	employee		12 VAC 5-371-300 (B) Cross Re to F-425	ference
	The findings included	٠.			12 VAC 5-371-180 Infection Con	froi
	On 3/3/16, a review conducted. Employe	of the employees file ee #20, a RN (regist	ered	İ	12 VAC 5-371-180 (A,B,C,1) Cros Reference to F-441	SS
· 1	nurse) did not have a nire.	a license check on fi	le prior to		12 VAC 5-371-370 Maintenance a Housekeeping	
	On 3/3/16 at 11:00 A conducted with the b	M, an interview was usiness office speci	alist		12 VAC 5-371-370 (A) Cross Refe to F-456	
į l	Employee (F). She so thecks here, then we	tated. "We did pur d	own		12 VAC 5-371-360 Clinical Record	is .
"	done on line by corpo Whatever you gave he employee file) is	prate." She went on me (information not	to state	Ì	12 VAC 5-371-360 (A,E) Cross Reference to F-514	
•	no employee lile/ is	what it is.			REC	EIVED
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State of Virginia STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 495252 a. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER-BATTLEFIELD PARK 250 FLANK ROAD PETERSBURG, VA 23805 (X4) IO PREFIX SUMMARY STATEMENT OF OFFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) -F 001 Continued From Page 3 F 001 12 VAC 5-371-140 (a) On 3/3/16 at 4:15 PM, the Administrator and 12 VAC 5-371-200 (E) Nurse Consultant were notified of above findings. COV 32.1-12.6.01 COV 32.1-12.6.01 1.) How the Corrective Action was accomplished for those residents Based on staff interview and facility found to have been affected. documentation review, the facility failed to obtain a No Residents were found to be affected sworn statement prior to hire for two employees. Employee #11 and Employee #20 in a survey The facility resubmitted the written notification to the OLC of DON change sample of 20 residents. dated 01/27/16 on 03/04/16 via fax. The findings included: 2.) How the facility will identify other residents having the potential to be Review of the employee files was conducted on affected by the deficient practice. 3/3/16. Employee #11 was hired on 10/19/15. Aii residents had the potential to be Her sworn statement was obtained after the hire affected. date on 12/15/15. 3.) The Following Measures will be put into piace or systematic changes Employee #20 was hired on 8/5/15. There was no made to ensure that the deficient sworn statement included within the employee's practice will not recur. file. The Facility HR Generalist, Business On 3/3/16 at 11:00 AM, an interview was Office Manager and Business Office conducted with the business office specialist, Assistant varified and validated all Licensa checks, swom statements has Employee (F). She stated, "We did our own been completed and are on file. checks here, then we switched over and they are done on line by corporate." She went on to state, The Exacutive Director in-serviced the "Whatever you gave me (information not found in Facility HR Ganeralist, Business Office the employee file) is what it is." She also stated Manager and Business Office Assistant on the requirements related to Licenses that Employee #20 was hired by a recruiter in and Sworn Statements on new hires. Portsmouth and they did not send the file. An audit wiii be completed by the On 3/3/16 at 4:15 PM, the Administrator and Business Office Assistant and or HR Nurse Consultant were notified of above findings. Ganeralist, or Business Office Manager to ensure compliance on all new hires 1. 12 VAC 5-371-200 Nursing Director weekiv. 12 VAC 5-371-200 (E) Based on the Code of Virginia and staff interview, the facility staff failed to notify the Office of Licensure and Certification (OLC) in writing with the name of the acting Director of Nursing (DON).

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STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIDENTIFICATION N	IER/CLIA UMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S	SURVEY ETED		
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	Continued From Pa The findings include On 3/3/16 at 10:30 survey team that sh would not be availal survey. She stated the available to answ. At this time, the DO when she officially be DON position. She On 3/3/16 at 1:00 p. verify that they had a of the DON change, written notification of the pool of the	ed: a.m., the acting DOI e was flying back hoole for the remainder that the Assistant Dover questions. N was asked for the regan to function in stated the date was m., the OLC was con received a written re The OLC did not he f the DON change. eeting on 3/3/16, the nine if the OLC had change. The facility	date the acting 1/27/16. Intacted to otification ave any	F 001	4.) The Facility will monitor its performance to make sure so are sustained. The Executive Director and or D Nursing will review the audits my 3 months and report the finding for analysis and recommendation up. 5.) Date Corrective Action will completed. Compliance Date is April 4, 2016	irector of control of onthly for in QAPI or follow			

DEPARTMENT OF HEALTH AND HULL IN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I -	TIPLE CONSTRUCTION ;.	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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GOLDEN	I LIVINGCENTER-BA	ITLEFIELD PARK		PETERSBURG, VA 23805	
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F 000	INITIAL COMMEN	rs ·	F 0	00	
	survey was conducted Corrections are red CFR Part 483 Federequirements. The survey/report will for investigated.	llow. Two complaints were		Preparation and/or execution of Correction does not constitute admission or agreement of the of the truth of the facts alleged conclusions set forth in the state deficiencies. The Plan of Correprepared and/or executed solel it is required by the provision of and State law.	te provider or ement of ction is v because
5 450	115 at the time of the consisted of 26 cur (Residents #1- #20 closed record revie #29).	120 certified bed facility was ne survey. The survey sample rent Resident reviews , #25-28, and #30-31) and 5 ws (Residents #21-24 and		This plan of correction is the fac credible allegation of compliance F 156	cility's ce.
SS=D	RIGHTS, RULES, S	483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 1	1.) How the Corrective Action accomplished for those resident found to have been affected.	was ents
	and in writing in a la understands of his regulations governi responsibilities duri	form the resident both orally anguage that the resident or her rights and all rules and ang resident conduct and ang the stay in the facility. The		Resident #22 was discharged o 01/26/16. Resident #23 was disc on 01/01/16.	n charged
	notice (if any) of the §1919(e)(6) of the	ovide the resident with the State developed under Act. Such notification must be		How the facility will identife residents having the potential affected by the deficient pract	to be lice.
	resident's stay. Re	on admission and during the ceipt of such information, and o it, must be acknowledged in		All residents who receive an Ad- Beneficiary Notice (ABN) have to potential to be affected. An Audi completed by the Business Office Manager and Social Worker and	t was
	entitled to Medicaid of admission to the resident becomes e items and services	orm each resident who is benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing er the State plan and for		Assessment Nurse by 04/01/16 identify those residents who hav received an Advanced Beneficia Notice.	to es
	•	may not be charged; those			

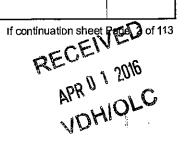
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

DEPARTMENT OF HEALTH AND HUM/ **3ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK STREET ADDRESS, CITY, STATE, ZIP CODE 256 FLANK ROAD PETERSBURG, VA. 23805 SUMMARY STATEMENT OF DEPLOIENCIES PREFER TAG SUMMARY STATEMENT OF DEPLOIENCIES PREFER TAG Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (I/A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for finose services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section, A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification and advocacy relevork, and the Medicaid fraud control	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	COM	E SURVEY PLETED
CAD ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAGK TAGK			495252	B. WING			· ·	
F 156 Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services, and inform each resident when changes are made to the Items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section, A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and	,		TTLEFIELD PARK		25	0 FLANK ROAD	<u> </u>	
other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETION
unit; and a statement that the resident may file a	F 156	other items and se and for which the r the amount of char inform each reside the items and serv (i)(A) and (B) of thi The facility must in at the time of admit the resident's stay, facility and of chargincluding any chargunder Medicare or The facility must fulegal rights which i A description of the funds, under parage A description of the funds, under parage A description of the for establishing elighthe right to request 1924(c) which deternon-exempt resounts itutionalization spouse an equitable cannot be considered toward the cost of medical care in his down to Medicaid. A posting of name numbers of all per groups such as the agency, the State ombudsman progradvocacy network.	rvices that the facility offers esident may be charged, and ges for those services; and nt when changes are made to ices specified in paragraphs (5) is section. form each resident before, or ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. Innish a written description of includes: emanner of protecting personal graph (c) of this section; erequirements and procedures gibility for Medicaid, including tan assessment under section ermines the extent of a couple's roes at the time of and attributes to the community ale share of resources which red available for payment the institutionalized spouse's or her process of spending eligibility levels. s, addresses, and telephone tinent State client advocacy estate survey and certification licensure office, the State ram, the protection and, and the Medicaid fraud control			Into place or systematic changes made to ensure that the deficient practice will not recur. The MDS Assessment Nurse, Sociative Worker, and Business Office Manawill be in-serviced by the Executive Director on Advanced Beneficiary Notification (ABN) process for compand compliance. 4.) The Facility will monitor its performance to make sure solution are sustained. The MDS Assessment Nurse, Sociative Manamet monthly at the facility Triple process meeting to validate compliance Advanced Beneficiary Notice (Aprocess. The results or findings with presented and discussed in Quality Assurance and Performance Improvement (QAPI) meeting for 3 months for analysis and review 5.) Date Corrective Action will be completed.	al ger pletion al ger will Check etion of ABN) Il be	



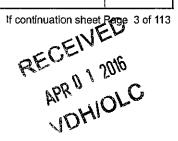
DEPARTMENT OF HEALTH AND HUM **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		` ´COM	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	1 SHOULD	BE	(X5) COMPLETION DATE
F 156	complaint with the sagency concerning misappropriation of facility, and non-coldirectives requirem. The facility must into name, specialty, an physician responsib. The facility must provitten information, applicants for admininformation about he Medicare and Medicare.	State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance	F1	56			
	by: Based on staff interest and clinical record of for two residents (F#22) to provide writted Advanced Beneficials. Resident #23 diese of the ABN as well which was submitted. Resident #22 diese of the ABN. The findings included. Resident #23 well.	d not have a written notification as the demand bill information ed late. d not have a written notification					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKt11



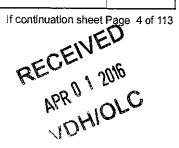
DEPARTMENT OF HEALTH AND HUN **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495252	B. WING		·		C 04/2016	
	PROVIDER OR SUPPLIER	TLEFIELD PARK		25	REET ADDRESS, CITY, STATE, ZIP CODE 10 FLANK ROAD ETERSBURG, VA 23805	1 00/	04/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 156	hypertrophy, low porthe most recent MI 10/30/15 coded the interview of mental possible 15, or no common most of total assistance of for ADL's (activities mobility and transfer Review of the residence was notified by photodocumentation was On 12/11/15, the fact from the QIO: "This the doctor disagreed discharge/termination non coverage was in issued in a manner On 3/3/16 at 10:40 at conducted with the lother E). She state QIO-quality improver receive the non coverage was in the ABN. Resident #22 was at 12/12/15. Diagnoses Alzheimer's dement recent MDS (minimulated the resident's mental status) score	otassium and dehydration. OS (minimum data set) dated resident's BIMS (brief status) score of "15" out of a cognitive impairment. The sident as requiring extensive of one to two staff members of daily living) such as bed rring. Lent's ABN dated 11/27/15 at's responsible party (RP) are of the ABN. No written provided. Cility received the following letter is a follow up was that d with your on of servicesThe notice of a twalidbecause it was not required by Medicare." AM, an interview was business office manager and, "Kepro (name of tement organization) did not	F 1	56				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11



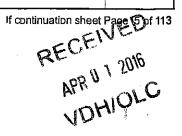
DEPARTMENT OF HEALTH AND HUM **3ERVICES** CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION ,	COME	SURVEY PLETED
	495252	B. WING	5	02/0	C 04/2016
NAME OF PROVIDER OR SUPPLIER	100202	L	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/0	J4/2010
GOLDEN LIVINGCENTER-BAT	TLEFIELD PARK		250 FLANK ROAD PETERSBURG, VA 23805		ų. 14
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY),	BE	(X5) COMPLETION DATE
assistance of one to (activities of daily liv transferring. Review of the ABN oresident's responsib phone of the ABN. provided. On 3/3/16 at 1:00 Pl nurse consultant we 483.10(b)(11) NOTII (INJURY/DECLINE/A facility must imme consult with the resiknown, notify the resor an interested famaccident involving thinjury and has the printervention; a significantly in either life the clinical complication significantly (i.e., a rexisting form of treaconsequences, or to treatment); or a decithe resident from the §483.12(a). The facility must also and, if known, the resor interested family in the second consequences and if known, the resor interested family in the second consequence and the second consequence and consequence are consequence and consequence and consequence and consequence are consequence and consequence and consequence and consequence are consequence and consequence and consequence are consequence and consequence and consequence are consequence and consequence and consequence and consequence are consequence and consequence and consequence are consequence and consequence and consequence and consequence are consequence and consequence and consequence are consequence and consequence are consequence and consequence and consequence are consequence and consequence and consequence and consequence are consequence and consequence and consequence are consequence and consequence and consequence are consequence and consequence are consequence and consequence and consequence are co	iring extensive to total two staff members for ADL's ing) such as bed mobility and dated 12/26/15 revealed the le party (RP) was notified by No written documentation was M, the Administrator and re notified of above findings. FY OF CHANGES	F 150		arty of blood 1/16 ther be have f ays of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11



DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG	COMPLETED
	·	495252	B. WING_		C 03/04/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	1 03/04/2010 *
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIC
F 157	resident rights under regulations as specthis section. The facility must recthe address and phologal representative. This REQUIREMENT by: Based on staff intereview, and clinical failed to inform the condition for one Resurvey sample of 3°. For Resident #28, the facility 2/4/13. Here findings included the	er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. It is not met as evidenced rview, facility documentation record review, the facility staff, physician of a change in esident (Resident #31) in a 1 Residents. The physician was not informed od sugar of 59 mg/dl ciliter) on 1/19/16 at 6:30 a.m. er.	F 15	3.) The Following Measures will into place or systematic changes made to ensure that the deficient practice will not recur. Licensed Nursing Staff will be inserviced by the Director of Nursing Services or Assistant Director of Nursing Services or Registered Nurse Superby 04/01/16 on Physician Notification Resident change in condition, included blood sugars that are out of parameter and other changes in condition. 4.) The Facility will monitor its performance to make sure solution are sustained. Blood Sugars will be monitored in the Clinical Start Up meetings by the Direct Nursing Services, Assistant Direct Nursing Services or Unit Charge Nurto ensure compliance with notification change in condition. Results of monitial be presented and discussed in Monthly Quality Assurance and Performance Improvement (QAPI) meetings for 3 months for analysis a review. 5.) Date Corrective Action will be completed. Compliance Date is April 4, 2016	irsing visor on for ding eters the rector tor of reses on of litors

If continuation sheet Edge of 113

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DEPARTMENT OF HEALTH AND HUM **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	·	COM	E SURVEY IPLETED
		495252	B. WING				C 04/2016
	PROVIDER OR SUPPLIER	TLEFIELD PARK		STREET ADDRESS, CITY, STAT 250 FLANK ROAD PETERSBURG, VA 23805	,	<u> </u>	<u>04/20 10</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION OATE
F 157	exception of bathing as requiring total as Review of Resident a signed physician's Accucheck two time Notify MD (Medical less than 60 or great on the most recently signed by the physic "Accucheck" is a find Review of the eMAF administration record entry for the fingers obtained twice a day the finger stick bloode: 30° a.m. was 59 m. A thorough review on evidence Reside notified of the finger mg/dl. When interviewed, to find nursing stated 3/ was no evidence the had been informed of 59 mg/dl. Review report also failed to informed. Guidance for nursin administration of me "Fundamentals of No physician is response."	stivities of daily living with the g. For bathing, she was coded sistance of one staff member. #28's clinical record revealed order that included, "5/25/15 as a day related to diabetes. Doctor) of BS (blood sugar) after than 400." The order was y "Order Summary Report" cian on 2/9/16. An ger stick blood sugar. R (electronic medication and diagramentation revealed an accompanying tick blood sugar to be y. Documentation revealed as ugar obtained 1/1/19/16 at g/dl. If the clinical record revealed and #28's physician was a stick blood sugar level of 59 are the ADON (assistant director 4/16 at 11:10 a.m. that there at Resident #28's physician of the finger stick blood sugar y of the facility's 24 hour reveal the physician had been	F1	57			
	unless they believe:	the orders are in error or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI t1

Facility ID: VA0021

If continuation sheet Vage 7 of 113

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	TIPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED		
		495252	B. WING	, , , , , , , , , , , , , , , , , , ,		C 0 4/2016	
,	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TTLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805		*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE	
F 225 SS=D	and ADON were inf staff to inform Resid finger stick blood st 12/10/16. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INDER The facility must no been found guilty of mistreating residenthad a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must en involving mistreatm including injuries of misappropriation of immediately to the atto other officials in atthrough established State survey and converted to the facility must haviolations are thorough revent further pote investigation is in present further potential further present further potential further present further	trator, corporate consultant, formed of the failure of the dent #28's physician of a ugar of 59 mg/dl, 3/4/16 at (c)(2) - (4) PORT DIVIDUALS of employ individuals who have f abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property, wledge it has of actions by a tran employee, which would for service as a nurse aide or of the State nurse aide or of the State nurse aide registry ties. Insure that all alleged violations tent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law of procedures (including to the entification agency). Insure evidence that all alleged ughly investigated, and must ential abuse while the		1.) How the Corrective Action was accomplished for those residents found to have been affected. An investigation was completed for Resident #3 on 03/03/16 and the inc was reported to the Office of Licensuand Certification (OLC) on 03/03/16. 2.) How the facility will identify oth residents having the potential to be affected by the deficient practice. The Executive Director or Director or Nursing Services or Assistant Direct Nursing or Charge Nurses will invest injuries of unknown origins in a timel manner and report per State regulation the appropriate agencies.	ident ire er e f or of igate		

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 8 of 113



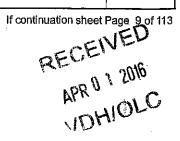
DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

495252 B. WING 03/04/2	2016
1 03/04/2	2010
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	Į.
GOLDEN LIVINGCENTER-BATTLEFIELD PARK 250 FLANK ROAD PETERSBURG, VA 23805	بيا هن
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY).	(X5) OMPLETION DATE
F 225 Continued From page 8 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed for 2 residents (Resident #3 and #8) of 31 residents in the survey sample to report and investigate injuries of unknown origin. The Fresident #3, an x-ray of the right foot completed on 2/26/16 revealed fractures of the third and fourth toes. The facility staff did not report the fractures to the Office of Licensure and Certification (OLC) and the facility staff did not investigate the fractures. 2. For Resident #8, the facility staff failed to notify the SA (state agency) of an injury of unknown origin that was observed on 6/26/15 until 6/30/15. "On 1/26/15 at 1900 (7 p.m.) resident was noted with a large red bruise on (R) (right) knee, no swelling or c/o (complaint of) tenderness noted to site." The findings included: Resident #3, a 90 year old, was admitted to the facility on 4/11/11. Her diagnoses included colon	

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Event ID: DNKI11



DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER:	l`'			СОМ	PLETED
		495252	B. WING			1	C 04/2016
	PROVIDER OR SUPPLIER	TLEFIELD PARK		2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805	1 00,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	cancer, diabetes, hidisease and Methicaureus (MRSA) in the Resident #3's most assessment was a assessment referer coded with a Brief I score of 15 indicating She required extensactivities of daily live Resident #3's physion 3/1/16. Included foot (plain film)" date A copy of the x-ray clinical record. The 2/26/16 at 4:15 p.m. "Impressions" read necks of the third a age indeterminate. On 3/2/16, the x-ray unit manager, Licer G). LPN G was as fracture. She state doctor was also aw referred to the x-ray hand wrote "(appointment)" and When asked if the notified of the fractures were asked again if the athe fractures, LPN	ypertension, degenerative joint illin-resistant Staphylococcus he right heel wound. recent Minimum Data Set quarterly assessment with an nee date of 12/8/15. She was nterview of Mental Statusing no cognitive impairment. sive assistance with her ing. dician order sheet was signed divas the order "X-ray right ted 2/26/16. report was included in the export was time stamped in The section titled "1. Nondisplaced fractures and fourth metatarsals (toes), in yreport was reviewed with the export was aware of the diversity of the fracture. She yreport where staff initialed, (Orthopedic doctor) appt dated 2/28/16. facility administration had been ured toes, LPN G stated that the age indeterminate. When administration was aware of G stated that the lid have been notified during		225			

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			TE SURVEY MPLETED
		495252	B. WING	3			C /04/2016
	PROVIDER OR SUPPLIER	ITLEFIELD PARK	·	STREET ADDRESS, CITY, STATE 250 FLANK ROAD PETERSBURG, VA 23805	, ZIP CODE	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	` <u>-</u>	CTION SHOULD O THE APPROPI	(X5) COMPLETION DATE	
F 225	Continued From pa	ge 10	F2	225			
	the end of day mee end of day meeting investigated Reside facility administration	tration was asked on 3/2/16 at ting and again on 3/3/16 at the if they had reported and ent #3's broken toes. The end did not provide any an investigation or LC.					
The state of the s	and Reporting Alleg Violation" was revie also the policy of thi steps to ensure that federal or state laws neglect, abuse, inju- misappropriation of violation") are repor-	led "Preventing, Investigating, ed Sexual Assault and Abuse wed. The policy read "It is is center to take appropriate all alleged violations of which involve mistreatment, ries of unknown source and resident property ("alleged ting immediately to the or Director of Nursing of the					
	reportable event resthe staff member shimmediately, but not forming the suspiciodoes not result in semember shall report 24 hours after forming the sults of all investig (executive director) appropriate state aglaw, within five work violation." 2. For Resident #8,	tled "Reporting" read "If the sults in serious bodily injury, sall report the suspicion to later than 2 hours after on." "If the reportable event erious bodily injury, the staff of the suspicion not later than any the suspicion." "The stations are reported to the ED or designee and to the lency, as required by stated ing days of the alleged.					
	origin that was obse	y) of an injury of unknown rved on 6/26/15 until 6/30/15. O (7 p.m.) resident was noted					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DNKI11

Facility ID: VA0021

If continuation sheet Page 11-04/3
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DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495252	B. WING				C)3/ 04/20 16
	PROVIDER OR SUPPLIER	ITLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805			3704/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	with a large red bruswelling or c/o (consite." Resident #8, a femathe facility 9/10/08 a hospitalization 8/4/1 hypothyroidism, ded disorder, unspecifie hypertension, arteridisease, and gastron Resident #8's most set) with an ARD (a 11/24/15 was coded as memory deficits and assistance of one sactivities of daily living Review of the facilit submitted to the SA #8 had been observing or c/o (comsite." Documentation reveausesesed by the staresponsible party winitial FRI to the starand no evidence was	ise on (R) (right) knee, no applaint of) tenderness noted to alle, was initially admitted to and readmitted after a 10. Her diagnoses included mentia, major depressive ad psychosis, anxiety disorder, osclerotic cardiovascular resophageal reflux disease. The recent MDS (minimum data assessment reference date) of das a quarterly assessment, having short and long terminated required extensive to total taff member to perform hering. The reported incident (FRI) and 6/30/15 revealed Resident	F 2	25			
1	injury of unknown of Review of the facility	y's policy entitled "Preventing.					3

DEPARTMENT OF HEALTH AND HUM **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B, WING				C 04/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 250 FLANK ROAD PETERSBURG, VA 23805	IP CODE	1 03/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
	Assault and Abuse "Reporting: If the reportable ev bodily injury, the sta suspicion not later suspicion. Failure to report in result in disciplinary termination. Staff must report the the Executive Direct supervisor. The ED (executive appropriate state as law and also notified The director of nurs interviewed. The E was no longer with survey. The corpor interviewed, 3/4/16 would investigate a the injury of unknow reported in a timely survey, no rationale injury had not been SA. The acting administ director of nursing),	Reporting Alleged Sexual Violation" included: ent does not result in serious aff member shall report the than 24 hours after forming the the required time frames may action, including up to the suspicion of an incident to etor, Director of Nursing, or director) notifies the gency in accordance with state is the regional vice president." sing was unable to be D at the time of the incident the facility at the time of the factle consultant was at 10:17 a.m. She stated she at 10:17 a.m. She stated she at attempt to determine why and attempt to determine why are provided as to why the reported immediately to the determine of the staff to report	F 2	225			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

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		AND HUI\ I SERVICES			(FORM): 03/15/2016 1 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT). 0938-0391 TE SURVEY MPLETED
		495252	B. WING	·	,		C
NAME OF	PROVIDER OR SUPPLIER		 	ST	REET ADDRESS, CITY, STATE, ZIP CODE	_03/	<u>/04/2016</u>
GOLDEN	I LIVINGCENTER-BAT	TLEFIELD PARK		250	FLANK ROAD TERSBURG, VA 23805		.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)/	D BE	(X5) COMPLETION OATE
F 241 S S=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 2	241			
	manner and in an el	omote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality.					
	by: Based on observatidocumentation reviethe facility staff failed	on, staff interview, facility w, and clinical record review, d to provide personal privacy lesidents' #1 and #5) in a Residents.			· · ·		
	nurse) F did not pull way around. Resident #1 or roommate's side in the curtain between Resident #5, curtain between Resident #6, allowing the roommate receiving wound care	LPN F did not pull the privacy ident #5 and his roommate, te to see Resident #5		-	F 241 1.) How the Corrective Action waccomplished for those resider found to have been affected. Resident #1 and #5 privacy curta immediately inspected and adjust 03/04/16 so they would provide p during care. Charge Nurse was immediately in-serviced on 03/04 the need to provide full visual privabile providing care to residents.	ins were ted on nvacy	
	nurse) F did not pull i way around Resident care. Resident #1 co roommate's side in th Resident #1, a female	LPN (licensed practical the privacy curtain all the			2.) How the facility will identify residents having the potential of affected by the deficient practice. All residents have the potential to affected. An inspection of identification privacy curtains was conducted by Housekeeping on 03/04/16 and fivide on 03/25/16 to ensure the controlled privacy for the residents.	to be ce. be ed by the acility urtains	

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 170 113

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DEPARTMENT OF HEALTH AND HUMA **BERVICES** CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

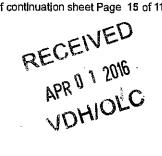
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPI A. BUILOING	LE CONSTRUCTION	COM	E SURVEY PLETEO
		495252	B. WING		1	
•	PROVIOER OR SUPPLIEF	'	1	STREET AOORESS, CITY, STATE, ZIP COOE 250 FLANK ROAD PETERSBURG, VA 23805		ų. se
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPROFICIENCY),/	OBE	(X5) COMPLETION OATE
F 241	set) with an ARD of 12/28/15 was cod Resident #1 was of term memory defi assistance with memory defi assistance with memory defi assistance with most also coded as one to two staff most daily living. Rehaving one stage www.npuap.org dulcer: "Category/Stage I Full thickness tiss tendon or muscle present. Often incurred tunneling. The depressure ulcer valures of the nose of th	st recent MDS (minimum data (assessment reference date) of ed as a quarterly assessment. Coded as having short and long cits and required total aking daily life decisions. She is requiring total assistance of tembers to perform her activities sident #1 was also coded as IV pressure ulcer. We fines a stage IV pressure V: Full thickness tissue loss ue loss with exposed bone, and should be shallow of a Category/Stage IV ries by anatomical location. The experience and complete and malleolus do the shallow. Category/Stage IV into muscle and/or supporting ascia, tendon or joint capsule) elitis or osteitis likely to occur. Juscle is visible or directly cobserved receiving pressure from LPN F, the facility's wound as beginning at 8:45 a.m. After upplies, LPN F put down a probable the privacy curtain the time that and her roommate. LPN F led the privacy curtain to the	F 241	3.) The Following Measures will be into place or systematic changes made to ensure that the deficient practice will not recur. Staff will be in-serviced by the Exec Director, Director of Nursing or Assis Director of Nursing Services by 04/0 on need to ensure that privacy is provided whenever care is being provided. 4.) The Facility will monitor its performance to make sure solutionare sustained. Cubicle Curtain and Window Curtain audits will be conducted by the Director Nursing Services or Assistant Director Nursing Services or RN Supervised times per week for 1 month then monthereafter to ensure residents are provided privacy during care. Result the audits will be presented and discussed in Quality Assurance and Process Improvement Meetings for months for analysis and review. 5.) Date Corrective Action will be completed. Compliance Date is April 4, 2016	utive stant 1/16 n stor ector ors 2 nthly	
	end of Resident#					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: ONKI11

Facility IO: VA0021

If continuation sheet Page 15 of 113



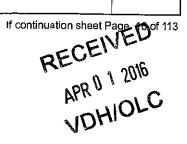
DEPARTMENT OF HEALTH AND HUM. **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495252	B. WING				C / 04/2016
	PROVIDER OR SUPPLIER N LIVINGCENTER-BAT	ITLEFIELD PARK		250	REET ADDRESS, CITY, STATE, ZIP CODE D FLANK ROAD TERSBURG, VA 23805	,	72010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE .	(X5) COMPLETION OATE
F 241	performed wound of While standing and Resident #1's room observed by looking opposite side of the #1's bed. Upon exit could also be easily as noted above. At reattaching Resider When interviewed, I p.m., he was unawaseen in the mirror. pulled the curtain all #1. Review of the facility Rights" included: "The Resident has tand confidentially of clinical records" Guidance is provide Nursing, 7 th Edition Applying Dry And McClose room or cubic Guidance is also pro Nursing, 7th Edition, of invasion of privace be free from unwant private affairs. HIPF Portability and According to the profession of privacy HIPPA standards have rais health care profession and privacy HIPPA	ge 15 are per the physician's order. observing the procedure, mate could be easily g into the mirror on the room at the end of Resident ting the room, Resident #1 observed in the same mirror that time LPN F was in #1's incontinent brief. LPN F stated 3/3/16 at 3:40 are that Resident #1 could be LPN F said he should have I of the way around Resident by policy entitled "Resident he right to personal privacy his or her personal and d by "Fundamentals of h, Potter-Perry, p. 1314, oist Dressings, Steps 5. ele curtains and windows." povided in "Fundamentals of h, Potter-Perry, p. 331, The tort y protects the client's right to red intrusion into his or her PAA (Health Insurance untability Act) Privacy ed awareness of the need for onals to provide confidentiality A sets forth standards s are entitled to confidential	F 2	41			
	director of nursing),	rator, ADON (assistant and corporate consultant e failure of LPN F to pull the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11



DEPARTMENT OF HEALTH AND HUMA *JERVICES* **CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B. WING	i			C 04/2016
	PROVIDER OR SUPPLIER I LIVINGCENTE R- B A			2	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	1 00/	0-4/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	privacy curtain all bed during wound 2. For Resident #scurtain between Rallowing the roomreceiving wound conceiving wound co	the way around Resident #1's care, 3/4/16 at 12:15 p.m. 5, LPN F did not pull the privacy esident #5 and his roommate, mate to see Resident #5 are. Ie, was admitted to the facility noses included sepsis, /perlipidemia, seizure, ession, hypertension, pulmonary ntestinal bleed, pneumonitis, ebrovascular accident. ot been at the facility long and MDS completed. Review of ing assessment revealed he d as having memory deficits tance with making life also assessed as requiring the his activities of daily living. The day having a stage II his sacrum. The fines a stage II pressure E Partial thickness as of dermis presenting as a rewith a red pink wound bed, any also present as an intact or purfilled or sero-sanginous ents as a shiny or dry shallow the or bruising*. This category is to describe skin tears, tape e associated dermatitis,	F2	241			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 17 of 113



PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUMAN, JERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD **GOLDEN LIVINGCENTER-BATTLEFIELD PARK** PETERSBURG, VA 23805 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY),/ F 241 Continued From page 17 F 241

Resident #5 was observed receiving wound care from LPN F 3/3/16 beginning at 9:05 a.m. After assembling his supplies, LPN F put a barrier down on the over bed table. LPN F pulled the privacy curtain between Resident #5's bed and the door, to the end of Resident #5's bed. No privacy curtain was pulled between Resident #5 and his roommate. Resident #5's roommate was alert and sitting up in his bed. LPN F preceded to perform pressure ulcer wound care per physician's orders. When interviewed, 3/3/16 at 3:40 p.m., LPN F did not remember that the privacy curtain had not been pulled between Resident #5 and his roommate. LPN F stated he should have provided privacy while performing wound care for Resident #5. The acting administrator, ADON, and corporate consultant were informed of the failure of LPN F to provide privacy for Resident #5 during wound care, 3/4/16 at 12:15 p.m. 483.15(e)(1) REASONABLE ACCOMMODATION

F 246 | 483.15(e)(1) REASONABLE ACCOMMODATION SS=D OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, family

Based on observation, staff interview, family interview, facility documentation review, clinical record review the facility staff failed to

F 246

F 246

 How the Corrective Action was accomplished for those residents found to have been affected.

Resident # 27 Care Plan and Care Card was reviewed and updated to reflect the resident's and family's preference.

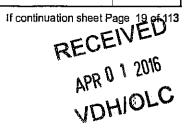
2.) How the facility will identify other residents having the potential to be affected by the deficient practice.

All residents have the potential to be affected. Nursing Services and Social Services will review the last 3 months of concerns and gnevances and care plan meeting notes for specific preferences and ensure that these have been care planned and communicated to the appropriate departments.

DEPARTMENT OF HEALTH AND HUMA . JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B. WING		1	C 04/2016
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		0-1120 TO
•	I LIVINGCENTER-BA			250 FLANK ROAD PETERSBURG, VA 23805		~
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
F 246	accommodate the (Resident # 27) in residents. For Resident # 27, her out of bed time preference. Findings included: Resident # 27 was to the facility on 2/2 but not limited to, 1 Stroke, Hemiplegia Gastrostomy, Major Episode, Hyperten Disease (GERD), a	needs of one resident a survey sample of 31 the facility staff failed to get ly per her and her family's a 60 year old female admitted 18/2012 with the diagnoses of, yea 1 Diabetes Mellitus, a and Hemiparesis, Aphasia, or Depressive Disorder, Single sion, Gastroesophageal Reflux and Cataract.	F 2	3.) The Following Measures winto place or systematic charmade to ensure that the deficience of practice will not recur. Staff will be in-serviced by the Nursing or Assistant Director of or Social Worker or Soc	Director of f Nursing ker resident by ces on ces will be meeting clan	
	quarterly assessment Reference Date (A coded Resident # 2 moderately impaire assistance of one activities of daily liv bowel and bladder On 3/3/2016 at 10: 27 lying in bed, lying tube feeding infusi 3/3/2016 at 11:30 / still lying in bed. On 3/3/2016 at 11: curtain pulled arou Resident 27 's fact was dirty with droot stated he was very	15 AM, observed Resident# ng on right side facing door,		logs will be audited monthly for by the Assistant Director of Nur Services and Social Worker or Worker Assistant to ensure con The results of these audits and will be presented and discusse Quality Assurance and Process Improvement Meetings for 3 m analysis and recommendations 5.) Date Corrective Action will completed. Compliance Date is April 4, 20	rsing Social rpliance. I reviews d in the s onths for	



DEPARTMENT OF HEALTH AND HUM **SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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		495252	B. WING			03/	04/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
GOLDEN	I LIVINGCENTER-BA	TTI EFIELD PARK		250 FLANK ROAD			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION OATE
F 246	Continued From pa	nge 19	, F 2	246			
	arrived and then pu each day. Husband her "because it did have to stay in the	ff would get her up after he at her back to bed by 2 PM d stated he would "just bathe d " not make sense for her to bed all day." Husband stated up and able to be around other					
	27's husband who meetings with the E of Nursing about ca Husband stated he morning care and gand for staff to take other residents. Hu loved being around benefit from the stir Activities" even the Husband stated he Coordinator about the Activity Room was uch as music, Binghe usually came to around 11:30 AM areach day." Husband etermine "what was progressively worse the bed longer and stated he felt that ceffort and he was was young and need On 3/3/2016 at 3 PI with RN (Registered would make sure the	ew conducted with Resident # of stated he had several executive Director and Director aring for Resident # 27. Trequested that she receive get out of bed before 11:30 AM of her to attend activities with sband stated that his "wife other people and could mulation of being with others in ough she could not talk. spoke with the Activities making sure his wife was in when activities were going on go and trivia. Husband stated the facility to visit his wife "at and would stay for 3-4 hours and stated he met with staff to be could do but things got be, staff quit and she was left in longer each day." Husband aring for his wife was a joint filling to work with the staff but she remained in bed until after days. Husband stated his wife ded to be kept active. Why an interview was conducted ded Nurse) B who stated she was staff got Resident # 27 out any and taken to activities. RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 20 of 113



DEPARTMENT OF HEALTH AND HUM! **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

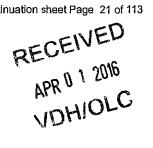
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		495252	B. WING	l		03/	04/201 6	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 250 FLANK ROAD PETERSBURG, VA 23805	CODE			
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F 246	early since that was benefit from attended on 3/3/2016 at 3:0 conducted with the A) who stated Residuring the times of Other A stated Residuring the times of Other A stated Residuring Dining Production of the A stated son Resident # 27 did get agitated. 3/3/2016 at 4:30 Pwith Activities Assiduring the times and Other A stated son Resident # 27 did get agitated. 3/3/2016 at 4:30 Pwith Activities Assiduring the times the program was going times when Residuring the times the program was going times when Other M did were going on whith Other M stated that Resident # 27 out of the group activities that did red by a tube. 3/4/2016 at 10:00 sitting in her whee attached sitting in group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the state of the group activity. The other residents in the group activity.	s their preference and would	F2	246				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 21 of 113



DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		495252	B. WING				C 04/2016
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/	04/2016
,					FLANK ROAD		
GOLDEN	I LIVINGCENTER-BAT	ITLEFIELD PARK	-	PET	TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY),	LD BE	(X5) COMPLETION DATE
F 246	Continued From pa	ge 21	F 2	46		,	
		ng around. Other M stated ned to be doing well in the					
	conducted with the (Other D) who state has complained ab earlier than 11:30 A	M, an interview was Social Services Director ed Resident # 27's husband out getting his wife out of bed M. Surveyor requested to reports written in the past 6 Resident # 27.			<u>.</u>	:	
	being wheeled by the near her room, hus were standing near stated he was very	M, observed Resident # 27 ne Activity staff in the hallway band and two other visitors by. Resident #27's husband happy to see her up and v. Resident # 27 smiled when to her.					
	presented two "Co 10/19/2015 and 11/ 10/19/2015 stated if very upset because stool, someone told staffed. Both report	mately 12 noon, Other D ncern Reports" dated 26/2015. The report dated Resident # 27's husband was " wife in bed playing in her I him " they were short ts were reviewed and signed tes Director and Administrator ach report.					
F 252 SS=D	often in bed at 11:3 the facility staff was expressed by the his COMPLAINT DEFIGURES. 15(h)(1)		F 2	52	F 252 1.) How the Corrective Action waccomplished for those resident found to have been affected. No Residents were found to be affected thousekeeping cleaned the area.	ts ;	

PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUMAN RVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA. 23805 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE OATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)./ F 252 Continued From page 22 F 252 2.) How the facility will identify other residents having the potential to be **ENVIRONMENT** affected by the deficient practice. The facility must provide a safe, clean, All Residents of Unit Two had the comfortable and homelike environment, allowing potential to be affected. the resident to use his or her personal belongings 3.) The Following Measures will be put to the extent possible. into place or systematic changes made to ensure that the deficient practice will not recur. This REQUIREMENT is not met as evidenced The Housekeeping Department will be inbv: serviced by the Executive Director or Based on observation and staff interview, the designee by 04/01/16 on the need to facility failed to maintain a clean environment for provide a clean environment for the one of two shower rooms. shower rooms. Environmental Round Audits will be The shower room floor on Unit two had several conducted daily Monday through Friday dark brown spots on the floor. LPN (A)(licensed by the Housekeeping Manager or practical nurse) was shown the shower room Housekeeping Assistant to check these floor. She gloved, obtained a paper towel and scrubbed at the floor. She stated, "It flakes right The Housekeeping Department will up." ensure the Shower Rooms are cleaned daily. On 3/3/16 at 9:00 AM, the shower room was observed to be clean and the floor was free from the dark brown spots. 4.) The Facility will monitor its performance to make sure solutions On 3/3/16 at 4:15 PM, the Administrator and are sustained. nurse consultant were notified of above findings.

FORM CMS-2567(02-99) Previous Versions Obsolete

resident's status.

F 278

SS=E

COMPLAINT DEFICIENCY

483.20(g) - (j) ASSESSMENT

ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the

A registered nurse must conduct or coordinate

each assessment with the appropriate

participation of health professionals.

Event ID: DNKI11

Facility ID: VA0021

completed.

F 278

The Executive Director or Management Designee will audit the Shower Rooms

weekly on an on-going basis. The results

of audit results will be presented and

recommendations and follow up as

5.) Date Corrective Action will be

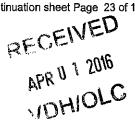
Compliance Date is April 4, 2016

analysis and review and

necessary for 3 months.

discussed in QAPI monthly meeting for

If continuation sheet Page 23 of 113



DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	PLE CONSTRUCTION	COM	SURVEY PLETED
		495252	B. WING		03/0) 9 4/2 016
•			•	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	, on	(X5) COMPLETION
TAG F 278	Continued From pa		F 278	1.) How the Corrective Action was	8	OATE
	Each individual who assessment must sthat portion of the a Under Medicare an willfully and knowin false statement in a subject to a civil me \$1,000 for each as willfully and knowin to certify a material resident assessme penalty of not more assessment.	o completes a portion of the sign and certify the accuracy of assessment. Id Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each		accomplished for those residents found to have been affected. Resident #11, 12 and 4 Interdisciplin Team (IDT) will be in-serviced on completion of Section C on the Minimal Data Set /Resident Assessment	nary mum leted concerning	
	by: Based on observar documentation revithe facility staff failed timely Minimum Da Instrument (MDS/F completed for four #12, #7 and # 4) in residents. 1. For Resident # 1 complete Section Cannual assessment	NT is not met as evidenced tion, staff interview, facility ew, and clinical record review, ed to ensure an accurate and ita Set/Resident Assessment (AI) assessment was residents (Residents # 11, in a survey sample of 31. 1, the facility staff failed to C: Cognitive Patterns in an it dated 12/10/2015. 2, the facility staff failed to		the presence of anti depressants. Residents with inaccurate coding will modified as needed. Assistant Director of Nursing/Designwill complete a review of MDS assessments completed within the la 30 days to determine Section C was completed.	l be	

	SS EOB WEDICADE	& MEDICAID SERVICES			FORM	APPROVED
						<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	COM	E SURVEY MPLETED
		495252	B. WING	<u> </u>	F	C / 04/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	04/2010
•			I	250 FLANK ROAD		_
GOLDEN	I LIVINGCENTER-BAT	TLEFIELD PARK	I .	PETERSBURG, VA 23805		y a .
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(Ve)
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 278	Continued From no	an 24				
1,210		-	F 278		put :	
		: Cognitive Patterns in the nt with an ARD of 2/1/2016.		into place or systematic changes made to ensure that the deficient practice will not recur.	•	
	3. Resident #7's MI use of an antidepres	DS was signed late and her ssant was not coded.		Director of Resident Assessment or Designee will provide education to the	e	
	, (,		Interdisciplinary team on the coding to Section C, timeliness of MDS and co	or]
	4. Resident #4's co	gnitive section (C) was not	- c- ·-	of use of antidepressants	aing	
	filled out and contain	ned only dashes.		4.) The Facility will monitor its	ľ	
	Findings included:			performance to make sure solution are sustained.	ıs	
	For Resident # 11 complete Section Cannual assessment	, the facility staff failed to : Cognitive Patterns in an dated 12/10/2015.		The Assistant Director of Nursing will audit a minimum of 3 MDS weekly to determine the accuracy of coding antidepressants and Section C. Finding	!	
	admitted to the facili	year old female, was ity 8/27/11. Her diagnoses ted to End Stage Renal		will be discussed in the Quality Assurance Process Improvement monthly meeting for 3 months by Dire of Nursing or Designee.	+	,•
-	Disease, lleostomy,	Hyperkalemia, Dementia, isorder, Cardiomyopathies,		5.) Date Corrective Action will be	t	
	Hemodialysis and H	ypertension.		completed.	: .	ľ
		t recent MDS (minimum data		Compliance Date is April 4, 2016	 	
	of 12/10/2015 was c	ssessment Reference Date) oded as an annual	l	· · ·		
		ent # 11's cognitive status	· ·			
	(her ability to make a	every day life decisions and				
	entered in the areas	not coded. Dashes were of Section C 100 "Should		-		
		ental Status" through C 1000".	:	· .		
	Cognitive Skill for Da	aily Decision Making."				
		oded as needing limited to				
		of one to two staff members				
		ties of daily living with the For eating, Resident # 11				
		ng only limited assistance.				
	Resident #11 was co	nded as being able to hear,				
	speak, understand, a					

DEPARTMENT OF HEALTH AND HUM SERVICES

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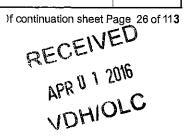
DEPARTMENT OF HEALTH AND HUM **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CDNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495252	B. WING				C 04/201 6	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE COMPL		
F 278	Continued From pa	ge 25	F 2	278				
		rided in "Long Term Care ssessment User's Manual 13, p. C-3						
	understood verbally understood, skip to Assessment of Mer 2. Review Languag the resident needs If the resident complete the interv Coding Instructions Record whether the attempted with the Code 0, no: if the inattempted because rarely/never unders or in writing, or an inavailable. Skip to C Mental Status. Code 1, yes: inattempted because sometimes underst if an interpreter is navailable. Proceed to C0200, CMS 's RAI Versio Items [C] May 2013 Page C-2	resident is rarely/never or in writing. If rarely/never C0700 - C1000, Staff Intal Status. e item (A1100), to determine if or wants an interpreter. needs or wants an interpreter, iew with an interpreter. e cognitive interview should be resident. Interview should not be the resident is stood, cannot respond verbally interpreter is needed but not 0700, Staff Assessment of If the interview should be the resident is at least ood verbally or in writing, and leeded, one is Repetition of Three Words. In 3.0 Manual CH 3: MDS	•					
	effort should be ma	needs an interpreter, every de to have an interpreter						

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Event ID: DNKI11



DEPAR [*] CENTE	TMENT OF HEALTH	I AND HUN	'SERVICES			(FORM	D: 03/15/2010 MAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
· <u></u>		,	495252	B. WING_			03	C
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		1	STI	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	/04/2016
	N LIVINGCENTER-BAT	··-				0 FLANK ROAD ETERSBURG, VA 23805		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS	ATEMENT OF DEA Y MUST BE PREC SC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION OATE
	needed interpreter to f the interview, cool interview not attemp C0700-C1000, Staff Status, instead of C Interview for Mental	to participate de C0100 = 0 pted and comf Assessmen C0200-C0500 Il Status. Itents who use of Interview for the ce p. 3-4: Ditems allow bubmitted to the cates that an itent often occurred before the capartial assessment in the purposes. It is a partial assessment in the purposes. It is interview (A2400C) that us indicate that the cample, if there e stay, then the A2400C) has this item would the control of th	o to indicate mplete nt of Mental D, Brief e American Sign or Mental Status a dash (-) value the MDS QIES item was not rs when a e item could be sessment to be is 100C, O0400A6, se a the event has not the end date for s not ould be	F 27	78			

include identification items in Section A [e.g.,

A0800)] and ICD-9 diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS

Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

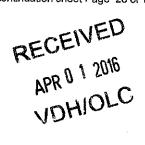
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495252	B. WING				C	
	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805					
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE	
F 278	MDS 3.0 Technical following link: http://www.cms.go atient-Assessment Instruments/Nursing 30TechnicalInform. The administrator, corporate consultation of the staff to compaccurately for an at 12/10/2015 during 3/2/2016. On 3/3/2016 at 5:2 conducted with Recoordinator (RN Cothe MDS (Minimum not complete the ir needed to be comprevious Registere Coordinator was or resigning in Februa should be complete No further information. 2. For Resident # 12 complete Section Courted at the faction of the fa	Information web page at the w/Medicare/Quality-Initiatives-P tagHomeQualityInits/NHQIMDS ation.html" DON (director of nursing), and ants were informed of the failure plete Section C100-C1000 annual MDS with the ARD of the end of day debriefing on the end of day debriefing on Data Set) meant the staff did aterview, but the interviews still pleted. RN C stated the do Nurse Assessment at sick for 3 weeks prior to ary. RNC again stated the MDS e and timely.	F2	278				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

if continuation sheet Page 28 of 113



DEPARTMENT OF HEALTH AND HU. ... N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: **0**3/15/2**0**16 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495252	B. WING		03	C / 04/20 16	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE	
F 278	make every day life was not coded. Da areas of Section C Mental Status" thro Daily Decision Mak coded as needing one to two staff me of daily living with the eating, Resident # limited assistance. always incontinent Resident #12 was a speak, understand, The administrator, I corporate consultar of the staff to compaccurately for an ar 12/10/2015 during to 3/2/2016. On 3/3/2016 at 5:20 conducted with Reg Coordinator (RN C) the MDS (Minimum not complete the inneeded to be compprevious Registered Coordinator was our resigning in Februa should be complete No further information. Resident #7's Mate and her use of coded. Resident #7 was accepted to the staff of the staff to complete the inneeded to be compositely as a supplementation. Resident #7's Mate and her use of coded.	gnitive status (her ability to decisions and memory ability) shes were entered in the 100 "Should Brief Interview for ugh C 1000" Cognitive Skill for ing." Resident # 12 was extensive to total assistance of mbers to perform her activities he exception of eating. For 12 was coded as needing only Resident #12 was coded as of bowel and bladder. coded as being able to hear, and be understood. DON (director of nursing), and hts were informed of the failure lete Section C100-C1000 anual MDS with the ARD of the end of day debriefing on DPM, an interview was gistered Nurse Assessment who stated that dashes on Data Set) meant the staff did terview, but the interviews still leted. RN C stated the d Nurse Assessment at sick for 3 weeks prior to ry. RNC again stated the MDS and timely.	F 2				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA002 t

If continuation sheet Page 29 of 113



PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUM! **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 29 F 278 obstructive pulmonary disease), anemia, and schizophrenia. The most recent MDS (minimum data set) dated 2/2/16 coded the resident's BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. The MDS coded the resident as requiring supervision assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. The resident was coded as having been treated with an antipsychotic and antianxiety daily for the past seven days of the ARD period. Review of the MAR (medication administration record) showed that Resident #7 had been treated with an antidepressant (Doxepin) daily for the past seven days of the ARD period. This was not coded on the MDS. In addition, the Z500

signed late.

Date (date RN-registered nurse) signed as complete) was more than 14 days after the ARD.

On 3/3/2016 at 5:20 PM, an interview was conducted with Registered Nurse Assessment Coordinator (RN C) who stated that dashes on the MDS (Minimum Data Set) meant the staff did not complete the interview, but the interviews still needed to be completed. RN C stated the previous Registered Nurse Assessment Coordinator was out sick for 3 weeks prior to resigning in February. RNC again stated the MDS

4. Resident #4's cognitive section (C) was not filled out and contained only dashes and was

Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The

The Z500 date was 2/23/16.

should be complete and timely.

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 5. A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495252	B. WING_	, , , , , , , , , , , , , , , , , , ,	- 1	C 04/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK				STREET AOORESS, CITY, STATE, ZIP COOE 250 FLANK ROAD PETERSBURG, VA 23805	1 03/	<i>₩</i>	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY),	LO BE	(X5) COMPLETION DATE	
F 278	most recent MDS (r 2/3/16 did not code interview of mental cognitive status bee only dashes. The properties of the BIMS score as "7" of moderate cognitive the resident as requestaff member for AL such as bed mobility. Review of the MDS information docume cognitive status, only cognitive section. In Date (date RN-regist complete) was more The Z500 date was of nursing) stated, "	minimum data set) dated the resident's BIMS (brief status) score nor had his en assessed, but contained revious MDS had coded the but of a possible 15 or impairment. The MDS coded uiring total assistance of one DL's (activities of daily living)	F 2'	78			
	instrument) manual "Item Z500 must be the ARD. On 3/2/16 at 5:00 P were notified of abo 483.20(d)(3), 483.10 PARTICIPATE PLAI The resident has the incompetent or othe incapacitated under	O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 28	1.) How the Corrective Action waccomplished for those residen found to have been affected. Resident #8 Care Plan and Care were updated to reflect the order found food placed in individual boand dietary department notified.	ts Card		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: DNKI11

Facility IO: VA0021

If continuation sheet Page 31 of 113



DEPARTMENT OF HEALTH AND HUL. A SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495252	B. WING	' ,	i i	C /04/2016
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		104/2010
•	I LIVINGCENTER-BA			250 FLANK ROAD PETERSBURG, VA 23805		*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 280	A comprehensive within 7 days after comprehensive as interdisciplinary te physician, a regist for the resident, ard disciplines as dete and, to the extent the resident, the relegal representative	care plan must be developed the completion of the seessment; prepared by an am, that includes the attending ered nurse with responsibility and other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's re; and periodically reviewed eam of qualified persons after	F 2	2.) How the facility will identify residents having the potential affected by the deficient practice. Residents who use adaptive equipment to be affected audit was conducted by the Dieta Services Manager by 03/21/16 or residents with orders for adaptive equipment to ensure that they we reflected on the Care Plan, Care and Dietary Matrix. 3.) The Following Measures we into place or systematic changemade to ensure that the defici practice will not recur.	to be ce. uipment and an ary if e ere card	
	by: Based on observation revenue facility staff fai comprehensive plant (Resident #8) in a Residents. For Resident #8, the separate bowls for The findings included Resident #8, a fent the facility 9/10/08 hospitalization 8/4 hypothyroidism, disorder, unspecific hypertension, arter	ention, staff interview, facility view, and clinical record review, led to review or revise the an of care for one Resident survey sample of 31 the use of physician ordered refood was not care planned. ded: nale, was initially admitted to and readmitted after a /10. Her diagnoses included ementia, major depressive ied psychosis, anxiety disorder, riosclerotic cardiovascular reesophageal reflux disease.		Dietary Staff were in-serviced by Dietary Services Manager by 03 that Physicians Orders for adapt equipment must be followed. No will be reviewed in clinical start updated as needed on Care Pla Care Cards. 4.) The Facility will monitor its performance to make sure so are sustained. Audits will be conducted by the Services Manager or Unit Manaweekly for 1 month then monthly months to ensure compliance a results of these audits will be brothrough the monthly QAPI meet discussion and further analysis recommendations and follow upsteps. 5.) Date Corrective Action will completed. Compliance Date is April 4, 201	dive sitive sup and ans and situtions sitution	
	by: Based on observation documentation revithe facility staff fai comprehensive plant (Resident #8) in a Residents. For Resident #8, to separate bowls for The findings included Resident #8, a fent the facility 9/10/08 hospitalization 8/4 hypothyroidism, disorder, unspecific hypertension, arter disease, and gasti	ation, staff interview, facility view, and clinical record review, led to review or revise the an of care for one Resident survey sample of 31 the use of physician ordered r food was not care planned. ded: nale, was initially admitted to and readmitted after a /10. Her diagnoses included ementia, major depressive ied psychosis, anxiety disorder, riosclerotic cardiovascular		Dietary Services Manager by 03 that Physicians Orders for adapt equipment must be followed. No will be reviewed in clinical start updated as needed on Care Pla Care Cards. 4.) The Facility will monitor its performance to make sure so are sustained. Audits will be conducted by the Services Manager or Unit Manaweekly for 1 month then month months to ensure compliance a results of these audits will be brathrough the monthly QAPI meet discussion and further analysis recommendations and follow upsteps. 5.) Date Corrective Action will completed.	dive sitive sup and ans and situtions sitution	

PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUM! 3ERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 32 F 280 set) with an ARD (assessment reference date) of 11/24/15 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required extensive to total assistance of one staff member to perform her activities of daily living. Resident #8 was observed in the restorative dining room, 3/2/16 at 12:10 p.m. She was sitting at a table and the staff brought her plate with her lunch. The plate contained meat and potatoes with gravy. In a small separate bowl was broccoli. She had thickened liquids to drink. Review of Resident #8's clinical record revealed the following physician's order, "8/19/14 Pt (patient) to have food placed in individual bowls at all meals in order to increase independence with self feeding." The order was on the most recently signed "Order Summary Report" dated as signed 2/17/16. Review of Resident #8's comprehensive care plan revealed a care plan had been developed 3/18/15 for "Inadequate Oral Food/Beverage intake due to Dementia. Food and beverage intake less than required. Resident is now receiving appetite stimulant and PO (by mouth) intake has improved. Included in the "Interventions" were: *Administer supplemental medications as ordered

during meals

*Diet as ordered

*Clothing protector as desired

*Invite to food related activities
*Medication review by pharmacist

*Identify the food and placement on plate/table

DEPARTMENT OF HEALTH AND H AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY IPLETED
		495252	B. WING				C 04/20 16
	PROVIDER OR SUPPLIER N LIVINGCENTER-BAT	ITLEFIELD PARK		STREET ADDRÉSS, CITY, STATE, ZIP (250 FLANK ROAD PETERSBURG, VA 23805	CODE		04/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD I	BE	(X5) COMPLETION DATE
	*Monitor for S/Sx (sidepression *Monitor meal cons *Monitoring through Committee *Monthly weights *Notify Physician ar weight change *Obtain and update *Provide assistance *Screen/evaluation needed) *Supplements and/o A thorough review or revealed no evidency had been care plant When interviewed, the stated 3/2/16 at 3:30 care plan to know he she further stated the assistants) had a "Reguidance to them for the "Resident Kardereviewed. While here ate in the "activity rowinformation was provided to the plan of care see for providing a writte the plan of care some	signs and symptoms) of umption daily weight Management of Meight Management of food/beverage preferences with meals by rehab services prn (as or snacks as ordered" of Resident #8's clinical record the use of separate bowls ned. The DON (director of nursing) of p.m., the staff utilized the low to meet Resident's needs. The CNA (certified nursing tesident Kardex" that provided in Resident needs. The Resident #8 was ar diet was listed and that she low for lunch and dinner" no wided that Resident #8 was to	F 2	80			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 34 of 113



DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	•		E SURVEY PLETED
	•	495252	B. WING	, i	_,	i .	0
NAME OF E	PROVIDER OR SUPPLIER	753232	5, 1, 1, 10 <u> </u>	STREET ADDRESS, CITY, S	STATE ZID CODE	03/	0 <u>4/20</u> 16
NAME OF I	·			250 FLANK ROAD	HAIE, ZIF CODE		_
GOLDEN	LIVINGCENTER-BA	TTLEFIELD PARK		PETERSBURG, VA 23	1805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S P (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION OATE
F 280	than one nurse, ph professional. A wripossible the coordi subspecialty consu diagnostic tests Y direct clinical nursir risk of incomplete, As the client's prob does the plan. A neguideline for coordi continuity of care, a be used in evaluati communicates nurshealth care profess plan enhances the listing specific nurs achieve the goals of for a given client winterventions throug client's length of sta	often receives care from more ysician, or allied health itten nursing care plan makes nation of nursing care, litations, and scheduling of ou design a written plan to ng care and to decrease the incorrect, or inaccurate care. Items and status change, so ursing care plan is a written inating nursing care, promoting and listing outcome criteria to on. The written plan sing care priorities to other sionals. The nursing care continuity of nursing care by ing interventions needed to of care. All nurses who care ill then carry out these nursing ghout a given day during a ay. A correctly formulated nakes it easier to continue	F 2	30			
F 281 SS=E	care from one nurs The acting adminis director of nursing) were informed of the the use of individual independence in ea 3/4/16 at 12:15 p.m 483.20(k)(3)(i) SEF PROFESSIONAL S The services provide must meet profession	trator, ADON (assistant and corporate consultant ne failure of the staff to ensure al bowls for all foods to foster ating to be care planned, at a corporate consultant necessity.	F 2	Residents #1, 8, 1 assessed for any a from missed treatr and none were for physicians were no	ective Action was or those residents een affected. 17, 20, 28, and 2 w adverse side effect ments and medical und. These resider lotified of the misse 21/16 and there we	Bre ts tions its'	

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		E CONSTRUCTION 3	СОМ	PLETED
		495252	B. WING			i	C 04/2016
,	PROVIDER OR SUPPLIER	TTLEFIELD PARK		25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805		*
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY),/	BE	(X6) COMPLETION DATE
F 281	review, and clinical failed to follow prof for seven Resident #20, #28, #4 and # Residents. 1. For Resident #1 administer treatme physician; 2. For Resident #8 ensure treatments by the physician; 3. For Resident #1 administer medical ordered by the phy 4. For Resident #2 administer medical ordered by the phy 5. For Resident #2 administer treatments physician; 6. For Resident #2 administer treatments physician; 7. For Resident #4 medications, included the physician's ordered	erview, facility documentation record review, the facility staff ressional standards of nursing ts (Residents' #1, #8, #17, 2) in a survey sample of 31. If the facility staff failed to nts as ordered by the series and treatments as sician, 20, the facility staff failed to tions and treatments as sician; 28, the facility staff failed to the same and treatments as sician; 28, the facility staff failed to the same and treatments as sician; 28, the facility staff failed to the same and treatments as sician; 21, the facility staff failed to the same and the same		281	2.) How the facility will identify of residents having the potential to affected by the deficient practice. The Field Services Clinical Director in-service the Director of Nursing or monitoring administration and documentation of treatments and medications to ensure Physician or are followed. Licensed nurses will be serviced by the Director of Nursing on Medication Management Guidelines regarding administration and documentation of treatments and medications by 04/01/16. 3.) The Following Measures will be into place or systematic changes made to ensure that the deficient practice will not recur. The Medication and Treatment Administration Records will be revise at the Clinical Start up Meeting for completion and appropriate follow upon the Clinical Start upon the Medication and Treatment Administration and Treatmen	will ders e in- or s exput	
	The findings included				Compliance Date is April 4, 2016		,
		1, the facility staff failed to ents as ordered by the			!		

FORM CMS-2567(02-99) Previous Versions Obsolele

Eveni ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 36 of 113



DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		495252	B. WING				C
NAME OF	PROVIDER OR SUPPLIER	+30232	1 5: 11,110		PET ADDRESS SITE OF THE SAME	03/	04/2016
	N LIVINGCENTER-BAT	ITLEFIELD PARK		250	REET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805		
(VA) ID	SUMMADVSTA	TEMENT OF DEFICIENCIES	15				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 36	F 2	81			
	physician,				· ·		
	6/13/13. Her diagn	ale, was admitted to the facility oses included sacral pressure tracture, Alzheimer's ertension.					·
	set) with an ARD (a 12/28/15 was coded Resident #1 was co term memory defici assistance with ma	recent MDS (minimum data assessment reference date) of d as a quarterly assessment. Oded as having short and long ts and required total king daily life decisions. She requiring total assistance of					
	one to two staff me	mbers to perform her activities dent #1 was also coded as					
		#1's clinical record revealed ents were not administered:					
	air loss mattress):	or pressure ulcer (specialty low 1/5/16 evening shift, 1/23/16 ay shift, 1/29/16 day shift, 3/16 day shift					
	1/5/16 evening shift	d to left lateral foot every shift: , 1/23/16 day shift, 1/24/16 ay shift, 2/4/16 day shift,					
	every shift: 1/5/16 e	ils to assist with bed mobility evening shift, 1/23/16 day hift, 1/29/16 day shift, 2/4/16 y shift					
į		shift: 1/5/16 evening shift, 24/16 day shift, 1/29/16 day ft, 2/8/16 day shift					

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY IPLETED
		495252	B. WING			1	C 04/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		2	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	1 00/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 37	F 2	:81		,	
· ·	with foam dressing:	essing twice daily and cover 1/23/16 day shift, 1/24/16 ay shift, 2/4/16 day shift,					
	centimeter) bulb se 1/5/16 evening shift	catheter with 10 cc (cubic cured with anchor every shift: 1,1/23/16 day shift, 1/24/16 ay shift, 2/4/16 day shift.			·		
i	evening shift, /23/16	t all times every shift: 1/5/16 3 day shift, 1/24/16 day shift, /4/16 day shift, 2/8/16 day shift					
		g to sheer wound of the 24/16, 1/29/16, 2/24/16					
ļ	Selsun Blue shamp 1/29/16	oo three times weekly:					
	treatments in questi record revealed no	ders were evident for the ion. Review of the clinical evidence Resident #1 refused lestion, nor that she was out					
		y's policy entitled "Medication eral Guidelines" included:					•
	medication dose red the resident's MAR record) directly after the end of each med administering the m	val who administers the cords the administration on (medication administration r the medication is given. At dication pass, the person edications reviews the MAR y doses were administered					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 38 of 113



PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUM **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 281 Continued From page 38 F 281 and documented. In no case should the individual who administer the medications report off-duty without first recording the administration of any medications. " When interviewed, RN (registered nurse) B stated 3/2/16 at 3:15 p.m., the administration of treatments followed the same standards as medications and should be documented as having been administered. After reviewing the documentation for the treatments. RN B stated the treatment nurse traditionally did all the treatments in the facility and was responsible for documenting them. RN B said on the days in question, the treatment nurse had to pass medications and that each nurse would have been responsible for their treatments. RN B stated she did not know if the treatments had been done, however she did not think they had been administered on the days in question. Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page. 705: Professional standards. such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication

administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

The right medication
 The right dose
 The right client
 The right route
 The right time

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		TE SURVEY
		495252	B. WING		0.	C 3/ 04/201 6
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		STREET ADDRESS, CITY, STATE 250 FLANK ROAD PETERSBURG, VA 23805		104/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 281	6. The right do The acting administ director of nursing), were informed of the administer the treat #1 per physician's of 2. For Resident #8 ensure treatments to by the physician. Resident #8, a femathe facility 9/10/08 a hospitalization 8/4/1 hypothyroidism, der disorder, unspecifie hypertension, arteriodisease, and gastron Resident #8's most set) with an ARD (a 11/24/15 was coded She was coded as in memory deficits and assistance of one sactivities of daily livit Review of Resident no evidence the foll administered on the Chair alarm every don day shift, 2/8/16 assist side rails on the sactivities of dails on the content of the sactivities of dails on the chair alarm every don day shift, 2/8/16 assist side rails on the content of the sactivities of dails on the chair alarm every don day shift, 2/8/16 assist side rails on the content of the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift, 2/8/16 assist side rails on the chair alarm every don day shift.	trator, ADON (assistant and corporate consultant e failure of the staff to ments indicated to Resident orders, 3/4/16 at 12:15 p.m. It the facility staff failed to were administered as ordered ale, was initially admitted to and readmitted after a 10. Her diagnoses included mentia, major depressive ad psychosis, anxiety disorder, osclerotic cardiovascular desophageal reflux disease. The recent MDS (minimum data assessment reference date) of the analysis and long term and required extensive to total traff member to perform her ang. #8's clinical record revealed owing treatments were	F 2	281		
	2/8/16 day shift, 2/2					

DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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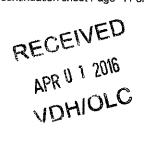
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X	3) DATE SURVEY COMPLETED
		495252	B. WING			C 03/04/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP C 250 FLANK ROAD PETERSBURG, VA 23805	ODE	30/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION TE OATE
	2/28/16 day shift Geri sleeves every on day shift, 2/8/16 Pads to arms of who on day shift, 2/8/16 Remove lap buddy every 1 hr (hour) and day shift, 2/8/16 day Wander guard contiday shift, 2/8/16 day Valid physician's ord treatments not docuadministered. Revierevealed no evidence the treatments or wathe time the treatment administered. When interviewed, first treatments followed medications and sho having been administed documentation for the treatments in the fact documenting them. question, the treatment medications and that been responsible for she did not know if the streatment of the document of the treatment of the treatment of the treatment of the treatment of the treatments in the fact documenting them.	ge 40 on day shift, 2/8/16 day shift, shift to bilateral arms: 2/4/16 day shift, 2/28/16 day shift eelchair at all times: 2/4/16 day shift, 2/28/16 day shift from wheelchair for 10 min d @ meal times: 2/4/16 on e shift, 2/28/16 day shift nuous every shift: 2/4/16 on e shift, 2/28/16 day shift from wheelchair for the mented as having been ew of the clinical record se Resident #8 had refused as out of the building during ents would have been RN (registered nurse) B of p.m., the administration of the same standards as each After reviewing the me treatments, RN B stated traditionally did all the collity and was responsible for RN B said on the days in ent nurse had to pass t each nurse would have the treatments. RN B stated the treatments. RN B stated the treatments had been did not think they had been	F 2	81		
	administered on the	days in question.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 41 of t13



DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY
		495252	B. WING			1	C / 04/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/	04/2010
GOLDEN	I LIVINGCENTER-BA	ATTLEFIELD PARK			FLANK ROAD 'ERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	Continued From page	age 41	F2	281			
	consultant were into administer the till #8 per physician's 3. For Resident #	strator, ADON, and corporate formed of the failure of the staff reatments indicated to Resident orders, 3/4/16 at 12:15 p.m. 17, the facility staff failed to tions and treatments as visician.	ı				
	the facility 4/1/10 a hospitalization 4/29 seizures, type II did depression, consti	male, was initially admitted to and readmitted after a 9/14. Her diagnoses included abetes mellitus, cataract, pation, hyperlipidemia, r disease, gastroesophageal d hypertension.					The second secon
	2/18/16 was coded Resident #17 was deficits and was at decisions. She wa extensive assistan perform her activiti exception of bathir	est recent MDS with an ARD of d as a quarterly assessment. coded as having no memory ble to make her own daily life as coded as needing limited to ce of one staff member to dies of daily living with the ag. For bathing she was coded assistance of one staff member.					
		nt #17's clinical record revealed Ilowing medication and Idministered:					,
	No pulses were ob	sure and pulse q (every) week: tained for the following weeks 21/16, 1/28/16, 2/4/16, 2/11/16, 16					
		ended release 650 1 tablet 1/16 at 2 p.m. 2/26/16 at 2					

FORM CMS-2567(02-99) Previous Versions Obsolete

Eveni ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 42 of 113



DEPARTMENT OF HEALTH AND HUL SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		495252	B. WING	.,	:		C /04/20 16
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TTLEFIELD PARK		250	REET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805	, ,	0-H2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 281	2/14/15 on evening Sure prep to first m shift: 2/1/4/16 on e When interviewed, p.m., the nurse that pressure and pulse computer, did not p area was entered for therefore the nurse B was unable to det treatments had bee administered. Review of the facilit Administration-Gen "Administration 2). Medications are with written orders of Documentation: 3). The resident's M administering the m provided under the specific medication on each MAR are of	every shift to abdominal folds: and night shift etatarsal on right foot every vening and night shift RN B stated 3/3/16 at 2:18 entered the order for blood to be obtained weekly in the ut the order in correctly. No or the pulse to be documented, did not obtain the pulse. RN termine if the medications and in administered or were not y's policy entitled "Medication eral Guidelines" included:	F 2	81			
	director of nursing,	rator, ADON (assistant and corporate consultant were					

DEPARTMENT OF HEALTH AND HUMA PERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION			E SURVEY MPLETED
	•	495252	B. WING					C /04/2016
	PROVIDER OR SUPPLIER			250	REET ADDRESS, CITY, STATE, ZIP CO D FLANK ROAD TERSBURG, VA 23805	DDE	1 03/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 281	medications and t	reatments as indicated to	F 2	281				
	12:15 p.m. 4. For Resident #	ohysician's orders, 3/4/16 at 20, the facility staff failed to ations and treatments as						
	Resident #20, a fe facility 11/1/13. He Parkinson's, anxie pulmonary disease cerebral pseudo so dementia, unspeci	male, was admitted to the er diagnoses included ty, chronic obstructive an anemia, hyperlipidemia, clerosis, epidemic vertigo, fied psychosis, paranoid thritis, and congestive heart					·	
	12/1/15 was coded Resident #20 was deficits and was all decisions. Reside extensive to total a members to perfor with the exception	est recent MDS with an ARD of as a quarterly assessment, coded as having no memory pole to make her own daily life ant #20 was coded as needing assistance of one to two stafferm her activities of daily living of eating. For eating, Resident requiring standby assistance eer.						
		nt #20's clinical record revealed llowing medications and dministered:						
ı	as needed: 1/15/1	o buttocks q (every) shift and 6 on evening shift, 1/31/16 on evening and night shift						
		e every shift: 1/15/16 on /16 night shift, 2/14/16 on shift						

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495252	B. WING			1	C 04/2016
	PROVIDER OR SUPPLIER			250	REET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805	1 03/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 44	F2	81			
		right thigh: 1/15/16 on evening hift, 2/14/16 on evening and					
		25 mg (milligram) by mouth 2/21/16 1 p.m., 2/26/16 1 p.m.	,				
	medications and tro of the clinical recor	order was evident for all the eatments in question. Review d revealed no evidence of the facility or had refused the ments in question.					
	presented to deteri	the survey, no evidence was mine if the medications and ot administered or if they were not documented.					
	consultant were inf to administer medi	trator, ADON, and corporate formed of the failure of the staff cations and treatments as ent #20 per physician's orders, n.					
		28, the facility staff failed to nts as ordered by the					
	facility 2/4/13. Her blind, anemia, atria mellitus, chronic re pulmonary disease vascular disease, o	male, was admitted to the diagnoses included legally all fibrillation, type II diabetes anal failure, chronic obstructive typerlipidemia, peripheral congestive heart failure, attack, and hypertension.					
		st recent MDS (minimum data					

DEPARTMENT OF HEALTH AND HUMA(CENTERS FOR MEDICARE & MEDICAID SERVICES

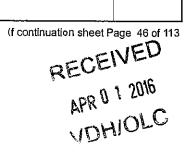
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY CDMPLETED	
	•	495252	B. WING			C 03/04/2016
	PROVIDER OR SUPPLIER VILIVINGCENTER-BAT	TTLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZI 250 FLANK ROAD PETERSBURG, VA 23805		00,01,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CRDSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281	1/6/16 was coded a Resident #28 was of deficits and was ab decisions. Resident minimal to stand by member with her ac exception of bathing as requiring total as Review of Resident no evidence the foll administered per ph Barrier cream every 1/29/16 A thorough review of no indication that R treatment or was no question. A valid physician's of treatment. The acting administ consultant were info to administer barrie and 1/29/16, 3/4/16 6. For Resident #4 medications, includi Resident #4 was ad 4/25/07. Diagnoses pneumonia, schizon most recent MDS (r 2/3/16 did not code interview of mental cognitive status bee	ss a quarterly assessment. coded as having no memory le to make her own daily life at #28 was coded as needing assistance of one staff ctivities of daily living with the g. For bathing, she was coded asistance of one staff member. #28's clinical record revealed owing treatments were hysician's orders: addy: 1/23/16, 1/24/16, of the clinical record revealed esident #28 refused the of at the facility on the days in order was evident for the arator, ADON, and corporate ormed of the failure of the staff or cream daily on 1/23, 1/24, at 12:15 p.m. the facility failed to document and an antibiotic. amitted to the facility on	F 2	81		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021



DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			СОМ	(X3) DATE SURVEY COMPLETED C	
		495252	B. WING			1	04/2016
	PROVIDER OR SUPPLIER	TTLEFIELD PARK		250	EET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	1X5) COMPLETION DATE
F 281	moderate cognitive the resident as req staff member for A such as bed mobiling. Review of the MAF record) for Februar medications not do are the omissions: 2/6/16: 2:00 PM-F subcutaneously everously everou	out of a possible 15 or impairment. The MDS coded uiring total assistance of one DL's (activities of daily living) ty and transferring. R (medication administration by 2016 revealed several ocumented as given. These ocumented as given. The ocumentation ocupented ocumented ocumented as given. The ocumented ocumen	F 2	281			

DEPARTMENT OF HEALTH AND HUL SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495252	B. WING				C (0.4/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	. <u>11. </u>		250	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 281	The most recent Mi quarterly assessme Reference Date (Al coded Resident # 2 severely impaired; activities of daily livincontinent of bowe catheter for bladder #2 was coded as refeeding tube and foulcer. The MDS deulcer as follows, "F exposed bone, tendeschar may be preswound bed.) Review of Resident no evidence that the administered: "Medihoney Wound Right Middle Shin to open area. Clean wapply Medihoney ar 1/23, 1/24, 1/29/16. Santyl Ointment 250 sacrum topically ever Clean with NS and of 1/29/16. Barrier Cream to bil for excoriation- 1/5/16 evening shift	inimum Data Set (MDS) was a sent with an Assessment RD) of 1/21/16. The MDS with cognitive status as required total assistance with ing (ADLs) and always I and as having an indwelling relimination. Resident receiving nutrition by way of a relimination by way of a relimination by way of a relimination by way of a relimination. Resident receiving nutrition by way of a relimination. Resident receiving a Stage IV pressure scribes as Stage IV pressure ull thickness tissue loss with ion, or muscle. Slough or sent on some parts of the sent on some parts of the defollowing treatments were reliable to the properties of the sent on some parts of the reliable to the properties of the sent on some parts of the reliable to the properties of the sent on some parts of the reliable to the properties of the reliable to the reli	F 2	81				

DEPARTMENT OF HEALTH AND HUM . SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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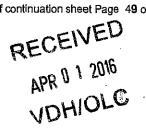
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 4. A. BUILDING			(X3) DATE SURVEY COMPLETED		
	~ **	495252	B. WING		4	1	0
			D. WING		DEST ADDRESS OF VICTORS 710 CODE	03/0	04/2016
NAME OF F	PROVIDER OR SUPPLIER]		REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER-BA	TTLEFIELD PARK			0 FLANK ROAD		*
		•	i	PE	TERSBURG, VA 23805		v ^a
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY),/	BE	(X5) COMPLETION DATE
F 281	Continued From pa 1/5/16 evening shi Silver Absorbent D 1/5/16 evening shi	ft. ressing to right middle shin -	F 2	81	F 309	,	
	ulcer - 1/5/16, even A valid physician's treatments in queston 3/2/16 at 5:00 pwas informed of the documented as had a the facility cited Liprofessional stand. On 3/4/16, at 2:15 corporate consultation of the staff to ensudocumented as per stand of the stand	order was evident for the tion. o.m., the director of nursing e treatments that were not ving been administered. ppincott as their reference for			1.) How the Corrective Action waccomplished for those residen found to have been affected. Resident # 29 expired on 01/04/16 Residents 1, 2, 4, 6, 8, 17, 20, 28 assessed for any adverse side efficient missed treatments or medical and found to have none. These residence currently receiving medications treatments as ordered. The residence physicians were notified by 03/21/17 the missed treatments and medical with no new orders received. 2.) How the facility will identify or residents having the potential to affected by the deficient practice	s. were ects sidents and ents' 16 of tions	
F 309 SS=E	Each resident must provide the necess or maintain the hig mental, and psych accordance with the and plan of care. This REQUIREME by:	CARE/SERVICES FOR BEING It receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in he comprehensive assessment INT is not met as evidenced httion, staff interview, clinical	F3	09	The Field Services Clinical Director educate the Director of Nursing Ser on Validation, medications obtained administered. Licenses nursing stat be in-serviced by 04/01/16 by the Director of Nursing Services, or Ass Director of Nursing Services on Medication Administration Guideline ordering medications from the pharm medications available in the Automa Dispensing Unit (ADU) and utilizing Emergency Drug Kits (EDK) to obtain medications as needed. The Director Nursing or Assistant Director of Nursill educate nurses on documenting medications and treatments as administered.	will vices I and if will sistant es, macy, atic the in of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 49 of 113



DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		CONSTRUCTION		E SURVEY IPLETED	
					h , ,	1	С
	ì	495252	B. WING				04/2016
:	PROVIDER OR SUPPLIER	TTLEFIELD PARK		250	REET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY),/	OULD BE	(X5) COMPLETION DATE
F 309	in the course of a confacility staff failed to attain or maintain to being for nine Res #8, #17, #20, #28, of 31 Residents. 1. For Resident #2 administer Enoxal Ciprofloxacin (an acorders; and 2. For Resident #2 administer treatment physician; 3. For Resident #4	age 49 lity documentation review, and complaint investigation, the oprovide care and services to he highest practicable well idents (Residents' #29, #6, #1, #4 and #2) in a survey sample 29, the facility staff failed to parin (a blood thinner) and intibiotic) per physician's 1, the facility staff failed to ents as ordered by the 6, the facility staff failed to were administered as ordered	F:	309	3.) The Following Measures winto place or systematic chan made to ensure that the defici practice will not recur. The Unit Managers will review orders and verify medications had betained, follow up with pharma the attending physician for new instructions when medications a available and report finding to the Director of Nursing Services or A Director of Nursing Services. The Medication and Treatment Admirecords and physician orders will reviewed at the Clinical Start up completion and follow up: 4.) The Facility will monitor its performance to make sure solare sustained.	ges ent new ave been cy and or re not e Assistant e nistration be for	
	by the physician; 4. For Resident # administer medica ordered by the phy 5. For Resident # administer medica ordered by the phy 6. For Resident # administer treatme physician; 7. For Resident # administer medica 8. For Resident #	17, the facility staff failed to tions and treatments as vician, 20, the facility staff failed to tions and treatments as vician; 28, the facility staff failed to ents as ordered by the 4, the facility failed to tions, including an antibiotic; 2, the facility staff failed to			The Reviews will be analyzed a discussed at the Facility Quality Assurance and Performance Asmeeting monthly for 3 months for discussion, analysis and recommendations. 5.) Date Corrective Action will completed. Compliance Date is April 4, 2016	sessment, r be	
	perform treatment	s as per physician's orders.		•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 50 of 113



DEPARTMENT OF HEALTH AND HU. AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	0	X3) DATE SURVEY COMPLETED	
		495252	B. WING			C 03/04/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER-BA	•		STREET ADDRESS, CITY, STATE, ZIP CO 250 FLANK ROAD PETERSBURG, VA 23805	DDE		4/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION OATE
F 309	9. For Resident # 1 clarify an order for include parameters	age 50 6, the facility staff failed to Accu-Check blood sugar to and did not notify the ed blood sugar results of 562	F3	509			
	administer Enoxap	ed: 9, the facility staff failed to arin (a blood thinner) and ntibiotic) per physician's					
	7/17/15 and died and diagnoses included second and sixth contraction, adult Alzheimer's, urinary disorder, major dep	ale, was admitted to the facility the facility 1/4/16. His I schizophrenia, non-displaced ervical vertebrae, failure to thrive, conjunctivitis, y tract infection, anxiety pressive disorder, ptosis, reflux disease, and					
	set) with an ARD (a 12/16/15 was code assessment. He w memory deficits an daily life decisions. extensive to total as	st recent MDS (minimum data assessment reference date) of d as a significant change as coded as having no d was able to make his own He was coded as needing assistance of one to two staff m his activities of daily living.					
		t #29's clinical record revealed d a fall at the facility 12/4/15					

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 51 of 113

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DEPARTMENT OF HEALTH AND HUMA. ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495252	B. WING		_		C 04/2016	
	PROVIDER OR SUPPLIER	ITLEFIELD PARK		STREET ADDRESS, CITY, S 250 FLANK ROAD PETERSBURG, VA 23	·		<u>04/2010 </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD I CED TO THE APPROPR EFICIENCY)	BE	(X5) COMPLETION OATE	
F 309	and was sent to the Resident #29 was r 12/11/15. Included an order for "12/11/ (milligram)/0.3 ml (r subcutaneously ever vein thrombosis)." injection made right subcutaneous tissus An accompanying explication medication to be a.m. and 9 p.m. Resident either time with a the reader to the number of the medication was available from the publications. Reviewed F3/4/16 at 10:42 a.m why Enoxaparin has available from the publications. Reviewed F3/4/16 at 10:42 a.m why Enoxaparin has available from the publications. Reviewed F3/4/16 at 10:42 a.m why Enoxaparin has available from the publications. Reviewed F3/4/16 at 10:42 a.m why Enoxaparin has available from the publication supply li was in the emergen been available for u are aware of the supply for Resident www.nlm.nih.gov pradministration of Erenoxaparin is used leg in patients who as a supply for Resident www.nlm.nih.gov pradministration of Erenoxaparin is used leg in patients who as a supply for Resident was a supply for Resident www.nlm.nih.gov pradministration of Erenoxaparin is used leg in patients who as a supply for Resident was a supply fo	hospital for treatment. eadmitted to the facility on with his admission orders was 15 Enoxaparin Sodium 30 mg milliliter) Inject 1 application ery 12 hours for DVT (deep A subcutaneous injection is an it under the skin and into the e. entry was placed on the eMAR on administration record) for e administered twice daily at 9 eview of the eMAR revealed ministered 12/11/15 at 9 p.m. edication was not administered note on the eMAR referring rsing notes. If, entries were made indicating not administered as it was not sharmacy. RN (registered nurse) B stated in the emergency supply of w of the emergency sting indicated the medication cy supply and would have se. RN B stated the nurses oply and how to access the use. ovides guidance for the	F3	309				

DEPARTMENT OF HEALTH AND HUI(I SERVICES
CENTERS FOR MEDICARE & MEDICAL	D SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION I IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION ILDING	(X3) DATE SURVEY COMPLETED
495252 в. wi		C 02/04/0040
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	03/04/2016
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)	
F 309 Continued From page 52 stomach surgery. It is used in combination with aspirin to prevent complications from angina (chest pain) and heart attacks. It is also used in combination with warfarin to treat blood clots in the leg. Enoxaparin is in a class of medications called low molecular weight heparins. It works by stopping the formation of substances that cause clots. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use enoxaparin exactly as directed. Do not inject more or less of it or inject it more often than prescribed by your doctor. Continue to use enoxaparin even if you feel well. Do not stop taking enoxaparin without talking to your doctor." Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "11). If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit." Additionally, another order was included on the admission orders obtained for Resident #29 by the facility staff and included: "12/11/15 Cipro tablet (Ciprofloxacin HCL) Give 1 tablet by mouth ever 12 hours for UTI (urinary tract infection) for three days." An entry was placed on the eMAR for Resident #29 to be administered Cipro twice daily beginning at 9 p.m. on 12/11/15. Nurses' initials indicated the medication was administered on 12/11/15 at 9 p.m. and 12/12/15 at 9 a.m. The entry was discontinued and reentered on	= 309	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DNKItt

Facility ID: VA0021

If continuation sheet Page 53 of 113



	TMENT OF HEALTH	,		(FOR	ED: 03/15/2016 RM APPROVED	
STATEMENT	OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	JLTIPLE CONSTRUCTION (X3) [MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495252	B. WING	G	C 03/ 04/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE	IX5) COMPLETION DATE	
F 309	12/12/15 for the sar 500 mg Give 1 table UTI for 3 days." Nu indicating Cipro was from 12/12/15 at 9 p Calculation of the dc Cipro 500 mg was a four days not the thr physician. Review on new physician's of 12/12/15 regarding? Ciprofloxacin. When interviewed 3 was unable to determine the second receiving an inaccur Review of the facility Administration-Generally. Medications are with written orders of Guidance for nursing administration of me "Fundamentals of N physician is responsite treatment. Nurses funless they believe tharm clients." Guidance for administration your trof infection you have long to take ciproflow your prescription lab	ne dosage and timing, "Cipro et by mouth every 12 hours for reses' initials were entered administered twice daily o.m. through 9/15/15 at 9 a.m. oses administered indicated administered twice daily for ree days as ordered by the of the clinical record revealed order had been received the administration of 1/4/16 at 10:42 a.m., RN B mine why the order was time resulting in Resident 29 rate amount of Cipro. It is policy entitled "Medication eral Guidelines" included: a administered in accordance of the prescriber." It is practice for the edications is included in, ursing 7th Edition, p 336, The ollow physician's orders the orders are in error or	F3	309		

not understand. Take ciprofloxacin exactly as directed. Do not take more or less of it or take it

more often than prescribed by your doctor." The acting administrator, ADON (assistant

DEPARTMENT OF HEALTH AND HUMA. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

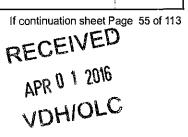
PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495252	B. WING	i		03	C / 04/2016
,	PROVIDER OR SUPPLIER			250	REET ADDRESS, CITY, STATE, ZIP COE FLANK ROAD TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	informed of the fa Enoxaparin and Corders, 3/4/16 at 2. For Resident # administer treatm physician, Resident #1, a fer 6/13/13. Her diagulcer, aphasia, codementia, and hyperity with an ARD 12/28/15 was code Resident #1 was a term memory defi assistance with m was also coded a one to two staff mof daily living. Rehaving one stage Review of Reside the following treatm of daily living. Rehaving one stage Review of Reside the following treatm following treatm of daily living. Rehaving one stage and the following treatm of daily shift, 1/24/16 Day shift, 2/4/16 Day shift, 2/4/16 Day shift, 2/8/16 day shift	and corporate consultant were illure of the staff to administer ciprofloxacin per physician's 12:15 p.m. If, the facility staff failed to ents as ordered by the male, was admitted to the facility gnoses included sacral pressure ntracture, Alzheimer's pertension. It recent MDS (minimum data (assessment reference date) of ed as a quarterly assessment, coded as having short and long cits and required total taking daily life decisions. She is requiring total assistance of tembers to perform her activities sident #1 was also coded as IV pressure ulcer. Int #1's clinical record revealed tements were not administered: If or pressure ulcer (specialty low 1/5/16 evening shift, 1/23/16 day shift, 1/29/16 day shift, 1/28/16 day shift, 1/23/16 day shift, 1/23/16 day shift, 1/23/16 day shift, 1/23/16 day shift, 1/24/16 day shif		309			
	Bilateral 1/2 side	rails to assist with bed mobility	1				

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Event ID: DNKI11

Facility ID: VA0021



DEPARTMENT OF HEALTH AND HUMA(ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B. WING	· ·	00	C
•	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 250 FLANK ROAD PETERSBURG, VA 23805	, ZIP CODE	/04/2016 *
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN	OF CORRECTION ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 313	one resident (Resid 31 residents was properties of the survice the days of the survice the days of the survice findings included Resident #4 was ad 4/25/07. Diagnoses presumonia, schizor most recent MDS (resident most recent MDS) (recent most recent m	ent #4) in a survey sample of covided his glasses for use. have his glasses on during rey. ed: Imitted to the facility on included dementia, ohrenia and diabetes. The minimum data set) dated the resident's BIMS (brief status) score. The previous BIMS score as "7" out of a grate cognitive impairment. The resident as requiring total taff member for ADL's ring) such as bed mobility and DS coded the resident use. M. Resident #4 was observed TV on. No glasses were in AM, the resident was care. His glasses were not the M. CNA (certified nursing estioned as to Resident #4's stated, "I give a bath, do objective cream and put him in rehab and I put him to bed	F 3	3.) The Following Mea into place or systemar made to ensure that the practice will not recurs. The Field Services Climin-service the Director of Services on following Particle by 04/01/16 by Nursing or Assistant Director of Services by 04/01/16 by Nursing or Assistant Director use of appropriate division. New orders for a will be reviewed in clinic Worker and or Social Wwill follow up on all grieved missing devices for vision. Audits will be conducted week for 3 months by the or Social Worker Assistate with assistive devices for compliance and these a brought through the more Assurance and Process meeting for further revier recommendations. 5.) Date Corrective Act completed. Compliance Date is April	ical Director will of Nursing lans of Care and opriate devices to g Staff will be in- the Director of ector of Nursing and care card evices to maintain ssistive devices al start up. Social orker Assistant rances on on. Iltor Its sure solutions d 2 times per e Social Worker ant of residents r vision to ensure udits will be athly Quality Improvement w and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 71 of 113

DEPARTMENT OF HEALTH AND HUMAN JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION (*)	СОМІ	(X3) DATE SURVEY COMPLETED C	
•		495252	B. WING _		03/04/2016		
1	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805		*	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 313	following: "Assist v with glasses as ne On 3/3/16 at 4:15 and nurse consulta findings. 483.25(h) FREE C	osis of diabetes, " revealed the vith placement and cleaning eded." PM, the facility Administrator ant were notified of the above	F 31	3	,		
SS=D	The facility must e environment rema as is possible; and	nsure that the resident ins as free of accident hazards each resident receives ion and assistance devices to			*		
	by: Based on observator documentation reverse the facility staff fail environment for two Resident # 21) in a residents. 1. For Resident # provide a hazard for hydrogen peroxide/det "Is a mild anitseption." 2. For Resident # maintain adequate	ation, staff interview, facility riew and clinical record review, ed to provide a safe ro residents (Resident # 31 and a survey sample of 31 31, the facility staff failed to ree environment as a bottle of was found at the bedside. .com/drugs/2/drug-76035/hydrails c used on the skin" 21, the facility staff failed to supervision to prevent him y to Resident #26. Resident		F 323 1.) How the Corrective Action accomplished for those reside found to have been affected. The bottle of hydrogen peroxide immediately removed from Resiroom on 03/03/16. Resident #21 had been discharg the facility on 07/09/15 2.) How the facility will identify residents having the potential affected by the deficient pract All residents had the potential to affected.	ents was dent # 31 ged from other to be ice.		

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 72 of 113

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DEPARTMENT OF HEALTH AND HUMA DERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION		E SURVEY (PLETED
í		495252	B. WING	in ,	1	C
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	04/2016
•	I LIVINGCENTER-BA			250 FLANK ROAD PETERSBURG, VA 23805		÷
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY),/	ULD BE	(X5) COMPLETION DATE
F 323	#21 was on one to wandered into Resigniury to his right a Findings included: 1. For Resident #3 provide a hazard find peroxide was founded to the facility with the Dementia, GERD (Disease), Diabetes Anxiety, Psychosis and Overactive Black The most recent Magnetic particular provided as meeding of one to two staff activities of daily like eating. For eating, independent and magnetic particular provided was observed to LPN H who was shift. When both magnetic particular provides was shift. When both magnetic particular provides was shift.	one supervision when he sident #26's room and caused rm and wrist. 31, the facility staff failed to ree environment as a bottle of d at the bedside. a 91 year old female admitted diagnoses of but not limited to (Gastroesophageal Reflux s, Chronic Kidney Disease, Major Depressive Disorder adder. Ilinimum Data Set (MDS) was a ent with an Assessment IRD) of 1/28/2016. The MDS is with BIMS (Brief Interview for M15 indicating cognitive status y impaired; Resident # 31 was limited to extensive assistance members to perform her ving with the exception of Resident # 31 was coded as eeding only set up. Resident # 4 eing able to hear, speak,	F 32	3.) The Following Measures winto place or systematic chammade to ensure that the deficipractice will not recur. A facility sweep was conducted 03/25/16 to ensure that there we hazardous materials left in resid rooms or common areas. The Director of Nursing or Assis Director of Nursing or RN Nurse Supervisor will educate Staff on maintaining close proximity to re on 1:1 and calling for assistance not able to maintain close proxim 4.) The Facility will monitor its performance to make sure solvare sustained. The Executive Director or Direct Nursing or Assistant Director of Nor RN Supervisor will in-service solv/01/16 on the need to keep restrooms and areas free from hazar materials, Residents who require supervision to maintain the safety others will be supervised based of individual occurrences and needs as 1:1, Q 15 minute checks. Audits of rooms and common area be conducted by the Departmenta Management Staff through our not clinical Rounds. Audits will be revand discussed and analyzed at our Monthly QAPI meetings for 3 mon recommendation and follow up. Or review of residents on 1:1 will be discussed and reviewed in QAPI. 5.) Date Corrective Action will be completed. Compliance Date is April 4, 2016	ges ient by ere no ent tant sidents when nity. utions or of lursing taff by ident dous such as will in niewed ir ths for ngoing	

DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED C			
		495252	B. WING			03/04/2016	
	PROVIDER OR SUPPLIE	R ATTLEFIELD PARK		250	EET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	medications or tre nurses said medications said medications or tre nurses said medications and the best of the bes	eatments by the bedside. Both cations and treatments were not did. LPN D stated she had ottle of Peroxide on the bedside 7-3 shift. LPN D took the bottle of e bedside table. LPN H stated ing to work and had not seen xide on the bedside table. Observed wandering in and out of hits during the survey. If day debrief on 3/3/2016 at 30 PM, the administrator and litants were informed that a bottle oxide was found on the bedside #31. ation was provided. #21, the facility staff failed to the supervision to prevent him ary to Resident #26. Resident to one supervision when he esident #26's room and caused arm and wrist.		323			

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 74 of 113

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DEPARTMENT OF HEALTH AND HUMA! ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ì		495252	B. WING	· · · · · · · · ·			C 04/2016
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP (250 FLANK ROAD PETERSBURG, VA 23805	CODE		04/20 16
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD APPROPE	BE	(X5) COMPLETION OATE
F 323	having the ability was also coded a one staff member living with the excussion was coded as new staff member. Reambulatory with life Further review of #21 was coded for out of six days du "a. Rejection b. Wandering c. Physical bothers. d. Verbal syne. Other behtoward others." A FRI (facility reperfacility was review 7/7/15 at which tir Resident #26's roinvestigation reversone supervision and that it took tw #21 to let go of Resident #26 was 3/10/14. His diag coronary artery dinon-Alzheimer's contact dermatitis Resident #26's as incident was a que 6/22/15. Resident	to be understood by others. He is needing limited assistance of to perform his activities of daily eption of eating. For eating he eding set up assistance of one esident #21 was coded for being mited staff assistance. The MDS revealed Resident or the following behaviors four ring the assessment period: of care. g. ehavior symptoms toward aptoms directed toward others. eavioral symptoms not directed orted incident) submitted by the orted incident submitted by the orted incident #21 entered on me Resident #21 entered on and grabbed his hand. The aled Resident #21 was on one of when the incident occurred to staff members to get Resident esident #26. Is admitted to the facility on noses included anxiety, sease, hypertension, dementia, depression and	F3	323			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 75 of 113

APR 0 1 2016

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DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495252	B. WING			С	
NAME OF	PROVIDER OR SUPPLIER	100202	D. 171110			03/	<u>/04/2016</u>
					EET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER-BAT	TLEFIELD PARK			FLANK ROAD		
				PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 32 3		-	F3	23	. —	-	
	clear comprehension and as having the authors. He was also assistance of one standard ADLs. Resident #20 ambulatory with limit Resident #26 was abehavioral symptom period.	oded as exhibiting no is during this assessment					
	at 5:45 p.m. Reside incident that occurre roommate was obse during the time of the	bserved in his room on 3/2/16 ent #21 did not recall the ed on 7/7/15. Resident #26's erved pacing in the room is observation. Resident #21 ks around a lot but he knows stuff."					
	exhibited wandering exit the facility on the into the facility, 7/2/1 notes, Resident #26 facility, was combatiout of residents' roor was noted as requirihad a wanderguard if #26 exited the facility contacted to re-direct Resident #26 was seroom for psych evaluation.	cal record revealed he behaviors and attempts to be second day of admission 5. According to the nurses' was not adjusting well to the ve and was wandering in and ms. On 7/3/15 Resident #26 ng frequent monitoring and in place. On 7/5/15 Resident y and the police were at him into the facility. Bent out to the emergency station. On 7/6/15 Resident accility with one on one staff					
!	"Resident wandered Resident was looking	note, dated 7/7/15 read, into another resident room. g at the resident pictures ent got mad and latched out					

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 76 of 113

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				D	OINITED.	02/45/2046
	MENT OF HEALTH	AND HUMAN ERVICES & MEDICAID SERVICES		(FORM.	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		495252	B. WING	,		C 04/2016
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER-BAT	TLEFIELD PARK		250 FLANK ROAD PETERSBURG, VA 23805		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY),/	BE	(X5) COMPLETION DATE
F 323	resident right hand resident to receive a bruise to right upper on 3/3/16 at 11:40 was conducted with assistant) B, the state one supervision at said the incident of and she was walking entered Resident # followed him into the come out and he wover to look at (his pictures. That's whoward him and Re CNA B said she initial assist her in getting after she got Resid #26's hand, she will #21 out of the room On 3/6/16 at 12:00 conducted with LP the unit manager. working at the time she was very familia	and arm. Causing the other and arm. Causing the other 3 skin tears to right hand and per arm." a.m., a telephone interview a CNA (certified nursing aff member providing one on the time of the incident. CNA B curred on the evening shift ag with Resident #21 when he 26's room. CNA B stated, "I be room and asked him to could not come out. He went name) Resident #21's ten Resident #21 reached out sident #26 grabbed his wrist" tially did not call for staff to a him out of the room and that ent #21 to release Resident as able to re-direct Resident	F 323	F 328 1.) How the Corrective Action waccomplished for those resider found to have been affected. The Oxygen tanks were immediate removed from Resident # 7 room 03/01/16 upon discovery. Resident #4 oxygen tubing and humidifier were changed on 03/02 and Resident #7 oxygen tubing a humidifier were changed on 03/03.	ately on 2/16 and 3/16.	

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NEEDS

F 328

SS=D

The administrator and corporate consultants were

advised of the failure of the staff to keep Resident

483.25(k) TREATMENT/CARE FOR SPECIAL

#26 safe from Resident #21's aggressive

behavior, 3/4/16 at 2:15 p.m.

COMPLAINT DEFICIENCY

EvenI ID: DNKI11

Facility ID: VA0021

F 328

If continuation sheet Page 77 of 113

residents having the potential to be

affected by the deficient practice.

All residents on oxygen have the

An Audit of residents with oxygen,

and all tubing and humidifiers were

humidifiers was completed by 03/03/16

potential to be affected.

changed as needed.

DEPARTMENT OF I				. (FORM): 03/15/2016 APPROVED
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES (X1) PROVIDI	ER/SUPPLIER/CLÍA CATION NUMBER:		PLE CONSTRUCTION	(X3) DA) <u>. 0938-0391</u> TE SURVEY MPLETED
		495252	B. WING		03	C / 04/2016
NAME OF PROVIDER OR S	JPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10-1/2010
GOLDEN LIVINGCENT	ER-BATTLEFIELD I	PARK		250 FLANK ROAD PETERSBURG, VA 23805		
PRÉFIX (EACH DE	MARY STATEMENT OF DI FICIENCY MUST BE PRE DRY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED OF T	ULD BE	(X5) COMPLETION OATE
The facility reproper treated special serve Injections; Parenteral and Colostomy, Tracheostor Tracheal surface Respiratory Foot care; and Prostheses. This REQUID by: Based on orienterview, face record review residents, (Face survey sample physician or control of the findings of the fi	and enteral fluids; ureterostomy, or ile my care; ctioning; care; and resident staff facility documentation w, the facility staff facility st	et as evidenced t and staff n and clinical ailed for two sident #4) in a to ensure provided. ks were not bing and ed for 21 days. er tubing and ed for 20 days. the facility on DPD (chronic	F 32	into place or systematic change made to ensure that the deficie practice will not recur. The Director of Nursing or Assista Director of nursing will in-service Nursing and Central Supply staff responsible for and on the need	es nt int the to s and 16. This rage tions	

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data set) dated 2/2/16 coded the resident's BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. The

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 78 of 113

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495252	B. WING		į	C		
	NAME OF PROVIDER OR SUPPLIER GOLDEN L!VINGCENTER-BATTLEFIELD PARK			STREET ADDRESS, CITY, STATE, ZIP C 250 FLANK ROAD PETERSBURG, VA 23805	CODE	03/04/2016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		SHOULD BE	BE COMPLÉTION		
	supervision assistal ADL's (activities of mobility and transfer coded as having relast seven 7 days. On 3/1/16 at 2:45 PResident #7 was obsmall oxygen cylind unsecured, beside the humidifier bottle #7 stated, "I asked have been rolling and On 3/1/16 at 3:30 Ptanks were checked one was full at 2000 RN (D) stated, "It should be stored in room." RN (D) prooffrom the room and pstorage room at 3:3 On 3/2/16 at 5:10 Proom. The oxygen humidifier bottle was On 3/2/16 at 9:20 Al humidifier bottle had resident stated that night and the oxyge when out of the room. On 3/2/16 at 2:55 Pl nurse (C) was taken.	sident as requiring no or nce of one staff member for daily living) such as bed bring. The resident was ceived oxygen therapy in the limit. The resident was ceived oxygen therapy in the limit. The closet. Oxygen tubing and was dated 2/10/16. Resident them to take them out, they round on the floor." M, the oxygen amounts in the limit by RN (registered nurse-D), limit prounds and one was empty. Though and one was empty. Though the oxygen was empty. Though the limit prounds and one was empty. Though the limit prounds and the oxygen was out of the concentrator tubing and the limit prounds and limit prounds and limit prounds. The she used her concentrator at an cylinders during the day m. M, LPN (licensed practical to the room. LPN (C) stated,	F3	328				
	On 3/2/16 at 2:55 Pl nurse (C) was taken "I don't know who is it is supposed to be	M, LPN (licensed practical						

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 79 of 113

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	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN ERVICES		(FORM	0: 03/15/2016 1 APPROVED 0: 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DAT	re survey MPLETED
		495252	B. WING _			C / 04/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVINGCENTER-BAT	TLEFIELD PARK		250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 328	Continued From pa	ge 79	F 32	28		
-	manufacturers reco cannula between or the most important change your cannul change the cannula sick or may be com keep bacteria in che	e clinical record revealed the				
		reated twice with oral and 3/1/16) for an upper				
-		t, the nebulizer tubing and s not changed for 20 days.				
	4/25/07. Diagnoses pneumonia, schizop most recent MDS (n 2/3/16 did not code interview of mental s cognitive status bee only dashes. The pr BIMS score as "7" o moderate cognitive ithe resident as requ	chrenia and diabetes. The minimum data set) dated the resident's BIMS (brief status) score nor had his en assessed, but contained revious MDS had coded the but of a possible 15 or impairment. The MDS coded viring total assistance of one DL's (activities of daily living)				

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dated 2/10/16.

On 3/1/16 at 5:05 PM, Resident #4 was observed in the bed with oxygen infusing at 2 liters per minute by nasal cannula. The humidifier bottle was dated 2/17/16 and nebulizer tubing was

On 3/2/16 at 8:40 AM, nebulizer and humidifier

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 80 of 113

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DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495252	B. WING	p 1	C 03/04/2016	
NAME OF PROVIDER OR	SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/0	U4/ZU16
GOLDEN LIVINGCEN	ITER-BAT	TLEFIELD PARK		250 FLANK ROAD PETERSBURG, VA 23805		ų. yž
PREFIX (EACH I	EFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY),/	BE	(X5) COMPLETION OATE
Review of was review cylinder or On 3/2/16 nursing) st weekly." On 3/2/16 were notifit COMPLAI 483.25(I) If Yes and Table 19 Septiments of the septiments o	e change the policy yed. It co istand." at 4:50 F ated the at 5:00 F ed of abo NT DEFI DRUG RE SARY D ent's dru ary drugs used in herapy); equate m for its us onsequer reduced ons of the a compre ne facility not used e drugs u necessal isted and of d residen ive gradu intervent	d with the date of 3/2/16. If for oxygen administration ntained the following: "Oxygen of the date of the following of the date of the changed of the following is to be changed over findings. CIENCY EGIMEN IS FREE FROM	F 32		ining tion new s s s s to be viced ant the ent	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 81 of 113

APR 0 1 2016 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B. WING			С	
NAME OF	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE	03	/04/2016
	I LIVINGCENTER-BAT	TLEFIELD PARK		25 0	FLANK ROAD TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY),/	D BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on observation documentation reviet the facility staff faile (Resident #5) in a swas free from unner For Resident #5, the blood pressures to to be administered. The findings include Resident #5, a male 2/26/16. His diagnor hypothyroidism, hyp Parkinson's, depresembolism, gastrointeinfluenza, and cereb Resident #5 had not enough to have an March the admitting nursing had been assessed and required assistance with He was documented pressure ulcer on his Resident #5 was observed.	ion, staff interview, facility ew, and clinical record review, d to ensure one Resident urvey sample of 31 Residents cessary medication. If facility staff failed to obtain determine if Lisinopril needed etermine if	F3	329	3.) The Following Measures will into place or systematic changes made to ensure that the deficient practice will not recur. Physician orders will be reviewed in clinical start up to ensure that the orare complete and that pre-assessment data is present as ordered. 4.) The Facility will monitor its performance to make sure solutionare sustained. The results of these reviews will be presented and discussed in QAPI from months for analysis and review and recommendations/action steps. 5.) Date Corrective Action will be completed. Compliance Date is April 4, 2016	n rders eent ons	
	and 3/3/16 at 5:02 p. was lying on his side	m. At both observations, he with the head of the bed					

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Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 82 of 113

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DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495252	B. WING	1		00	C
	PROVIDER OR SUPPLIER V LIVINGCENTER-BAT	TLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP (250 FLANK ROAD PETERSBURG, VA 23805	CODE	03	/04/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD I E APPROPR	BF	(X5) COMPLETION DATE
F 329	elevated. Resident verbal.	#5 was awake however non	F 3	329			
	an order that was in orders, "2/26/16 Lisi (milligram) via PEG-to ESSENTIAL (PRI Hold if SBP (systolic 100." A peg tube is inserted through the stomach. The tube	#5's clinical record revealed cluded with the admission nopril tablet Give 10 mg. Tube one time a day related MARY) HYPERTENSION blood pressure) < (less than) soft flexible tube surgically abdominal wall into the is utilized to administer and nutrition for a Resident allow.					
	medication administration by the administration of systolic blood pressure (millimeters of mercupressure is the uppe	ntry on the eMAR (electronic ration record) indicated administered daily from 16. No blood pressure evident indicating Resident had been obtained prior to Lisinopril to determine if the are was less than 100 mm/hg ary). The systolic blood r number of the blood ne pressure in the blood art beats.					
	Resident #5's blood p twice during the time 3/2/16, however the b	the clinical record revealed pressure had been obtained period from 2/26/16 through plood pressures could not be been obtained prior to the mopril.					
(of blood pressures wi stated, 3/2/16 at 4 p.r	N) B, after reviewing the lack ithin the clinical record m., the nurse entering the er failed to enter the order					·

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 83 of 113

DEPARTMENT OF HEALTH AND HUMAN LIRVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECȚION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
,		495252	B. WING	· 		1	04/2016
•	PROVIDER OR SUPPLIER	TTLEFIELD PARK	I	2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805		*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	LL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY),	BE	ÍX5) COMPLETION OATE
F 329	pressure reading. pressures had bee had been admitted admissions should blood pressure obt three days. Review of the facili Administration-Ger "2). Medications a with written orders Guidance for nursi administration of m "Fundamentals of I physician is respor treatment. Nurses	ng a space for the blood RN B stated only two blood n obtained since Resident #5 to the facility and all new , at a minimum, have their ained every shift for the first ty's policy entitled "Medication neral Guidelines" included: re administered in accordance of the prescriber."	F	329			1.
F 334 SS=D	responsible for doc data required of ce pressure measured medications, or lab of Dilantin before g The acting adminis director of nursing) were informed of the Resident #5's bloodetermine if Lisinol administered, 3/4/1 483.25(n) INFLUEI IMMUNIZATIONS	trator, ADON (assistant , and corporate consultant ne failure of the staff to ensure d pressure was obtained to oril 10 mg needed to be	F	334	F 334 1.) How the Corrective Action was accomplished for those resident found to have been affected. Resident # 20 was offered the Flu Vaccine and refused the Vaccine.	19 S	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 84 of 113

DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ' .	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		4952 5 2	B. WING	·	C 03/04/2016
•	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 334	(i) Before offering the each resident, or the representative receivements and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or the immunized during the contraindicated or the immunized during the contraindicated or the immunization; and (iv) The resident or representative has immunization; and (iv) The resident's redocumentation that following: (A) That the resident representative was the benefits and point immunization; and (B) That the resident influenza immunization on the facility must detend that ensure that— (i) Before offering the immunization, each legal representative the benefits and point immunization; (ii) Each resident is immunization, unless medically contraind already been immuniciii) The resident or	ne influenza immunization, e resident's legal ives education regarding the ial side effects of the offered an influenza per 1 through March 31 immunization is medically the resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical refusal. The pneumococcal resident, or the resident's receives education regarding tential side effects of the offered a pneumococcal is the immunization is icated or the resident has nized;	F 33	residents having the potential to affected by the deficient practice. An Audit of residents will be compiby 04/01/16 0f all residents to deteresidents who gave consent to receptu Vaccine.	be be c. leted mine eive be nges t nt or will sions ete the e oe in Status sure d as nd eview ly for lysis

DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495252	B. WING				C (0.4/2046	
	PROVIDER OR SUPPLIER	ITLEFIELD PARK	J	STREET ADDRESS, CITY, STATE, ZIP 250 FLANK ROAD PETERSBURG, VA 23805	CODE	1 US	/04/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTIO	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE	
F 334	immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal imm (v) As an alternative and practitioner reconneumococcal imm years following the immunization, unless	medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of funization; and ent either received the funization or did not receive emmunization due to medical refusal. e. based on an assessment ommendation, a second unization may be given after 5 first pneumococcal as medically contraindicated or resident's legal representative	F3	334				
	by: Based on observat record review, the fa one Resident (Resident grant) For Resident #20, was no evidence the administered. The findings include Resident #20, a fem facility 11/1/13. Her	ed: nale, was admitted to the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 86 of 113

DEPARTMENT OF HEALTH AND HUMA! ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495252	B. WING			C 03/04/2016	
	PROVIDER OR SUPPLIEI			250 F	ET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD ERSBURG, VA 23805	03/	04/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	t	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	pulmonary diseas cerebral pseudo s dementia, unspect delusions, osteoal failure. Resident #20's moset) with an (asset) with an was a decisions. Resident #20 was deficits and was a decisions. Resident extensive to total a members to perform with the exception #20 was coded as of one staff members to perform with the exception #20 was coded as of one staff members to perform was not an exception with the exception #20 was coded as of one staff members to perform was not an exception with the exception #20 was not an exception with the exception with the exception with the exception was not an exception with the exception was not an exception with the exception with the exception with the exception was not an exception with the exception with the exception was not an exception with the exception with t	e, anemia, hyperlipidemia, clerosis, epidemic vertigo, ified psychosis, paranoid rthritis, and congestive heart ost recent MDS (minimum data assment reference date)ARD of das a quarterly assessment. coded as having no memory ble to make her own daily life ent #20 was coded as needing assistance of one to two staff rm her activities of daily living of eating. For eating, Resident requiring standby assistance er. Resident #20 was coded as d the flu vaccine, with "9" he above) as the reason the dministered. Int #20's clinical record revealed in gave consent for the vaccine I in September, 2015. A f the clinical record, including immunization section, and o evidence the flu vaccine had	F3	334			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 87 of 113

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495252	B. WING	, h j	С	
		493232	B. WING		03/04/2016	
NAME OF	PROVIDER OR SUPPLIER		Ì	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER-BAT	TI FFIFI D PARK		250 FLANK ROAD	₩	
OOLDE	, ETTINGUENTEIN DAI	TER RED PARK		PETERSBURG, VA 23805	, a	
' (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVI	D BE COMPLÉTION	
,,,,			,,,,	DEFICIENCY)/		
F 334		ge 87 rator, ADON (assistant	F 33	34		
F 369 SS=D	director of nursing) informed of the failuthe flu vaccine to Reflu season, 3/4/16 a	and corporate consultant were use of the staff to administer esident #20 during the 2015 at 12:15 p.m. /E DEVICES - EATING	F 36	F 369 1.) How the Corrective Action was accomplished for those resident found to have been affected.		
		ovide special eating equipment dents who need them.		Resident # 8 Care Plan and Care were updated to reflect the order to having food placed in individual bo	or [
	by: Based on observat documentation revie the facility staff faile ordered assistive de	ting for one Resident		2.) How the facility will identify or residents having the potential to affected by the deficient practice. Residents who use adaptive equipment the potential to be affected at audit was conducted by the Dietan Services Manager by 03/21/16 of residents with orders for adaptive equipment to ensure that they were reflected on the Care Plan, Care Cand Dietary Matrix.	be	
	The findings included Resident #8, a femathe facility 9/10/08 a hospitalization 8/4/1 hypothyroidism, der disorder, unspecifie hypertension, arteriodisease, and gastro Resident #8's most	ysician ordered individual newere not implemented. ale, was initially admitted to and readmitted after a 0. Her diagnoses included nentia, major depressive d psychosis, anxiety disorder, osclerotic cardiovascular esophageal reflux disease. recent MDS (minimum data ssessment reference date) of		3.) The Following Measures will into place or systematic change made to ensure that the deficient practice will not recur. Dietary Staff were in-serviced by the Dietary Services Manager by 03/24 that Physicians Orders for adaptive equipment must be followed. New will be reviewed in clinical start up updated as needed on Care Plans Care Cards by Unit Managers Lie Nursing Staff will be in-serviced by 04/01/16 on the need to utilize Die Communication Slips/Forms by the Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor	t the 5/16 corders and and censed tary ector	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 88 of 113

DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED			
		40.5050	D. William		, , , , , , , , , , , , , , , , , , ,		
		495252	B. WING			03/	04/2016
	PROVIDER OR SUPPLIER LIVINGCENTER-BAT	TLEFIELD PARK		250	EET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD TERSBURG, VA 23805		×
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY),/	D BE	(X5) COMPLETION DATE
F 369	11/24/15 was coded as memory deficits an assistance of one sactivities of daily liv Resident #8 was obwas lying in bed slebrought in Resident her up for breakfas oatmeal in a bowl. sausage gravy and also observed in the 3/2/16 at 12:10 p.m and the staff brough The plate contained gravy. In a small so She had thickened oatmeal and brock individual bowls. Review of Resident the following physic (patient) to have for all meals in order to self feeding." The signed "Order Sum 2/17/16. Review of Resident plan revealed a car	d as a quarterly assessment, having short and long term d required extensive to total staff member to perform her ing. Diserved 3/2/16 at 9 a.m. She beging. A staff member to the tay and woke to the tray was fortified. On a regular plate was a waffle. Resident #8 was be restorative dining room, and the plate with her lunch. It meat and potatoes with deparate bowl was broccolialliquids to drink. Except for the bolial the foods were not in the tay was on the most recently mary Report dated as signed to the tay and been developed.		369	4.) The Facility will monitor its performance to make sure solution are sustained. Physician Order Audits for adaptive equipment will be conducted by the Dietary Services Manager or Unit Managers weekly for 1 month then monthly for 3 months to ensure compliance and the results of these audits will be brought through the monthly QAPI meeting for discussifurther analysis and recommendation and follow up / action steps. 5.) Date Corrective Action will be completed. Compliance Date is April 4, 2016	on and	
	intake due to Demo					·	
	included in the Thi	STACHTOURS AACTE:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 89 of 113

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DAT	E SURVEY
		495252	B. WING				C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 250 FLANK ROAD PETERSBURG, VA 23805	CODE	J U3/	(04/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE.	(X5) COMPLETION DATE
F 369	*Clothing protector *Diet as ordered *Identify the food a during meals *Invite to food relat *Medication review *Monitor for S/Sx (sepression *Monitor meal cons *Monitoring though Committee *Monthly weights *Notify Physician a weight change *Obtain and update *Provide assistance *Screen/evaluation needed) *Supplements and/ A thorough review of revealed no eviden had been care plan When interviewed, stated 3/2/16 at 3:3 care plan to know h She further stated to assistants) had a "F guidance to them for The "Resident Kard reviewed. While he ate in the "activity re information was pro- have individual bow	mental medications as ordered as desired nd placement on plate/table ed activities by pharmacist signs and symptoms) of sumption daily Weight Management nd family/responsible party of e food/beverage preferences with meals by rehab services prn (as or snacks as ordered" of Resident #8's clinical record ce the use of separate bowls ned. the DON (director of nursing) 0 p.m., the staff utilized the now to meet Resident's needs. he CNA (certified nursing Resident Kardex" that provided	F 3	369			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI1t

Facility ID: VA0021

If continuation sheet Page 90 of 113

	ATEMENT OF OEFICIENCIES IO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILOING B. WING STREET AOORESS, CITY, STATE, ZIP COOE 250 FLANK ROAD					
STATEMEN	T OF OEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA		IPLE CONSTRUCTION **	(X3) OAT COM	. 0938-0391 TE SURVEY MPLETEO
	İ	495252	B. WING _			C / 04/20 16
NAME OF	PROVIOER OR SUPPLIER		<u> </u>	STREET AOORESS, CITY, STATE, ZIP COOE	1 03/	04/20 0
GOLDE	N LIVINGCENTER-BAT	TLEFIELD PARK		250 FLANK ROAD PETERSBURG, VA 23805		ų. V
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL BC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF	O BE	(X5) COMPLETION DATE
F 369	Other P was in the of that when any order needs, nursing was form to inform dieta Other P said she was Resident #8 to have	dietary department and stated is obtained regarding dietary to fill out a communication ry of whatever the need is. as unaware of any order for e separate bowls for her food. ation from "Momentum Meal	F 36			
	Matrix" was provide system utilized by di Resident 8's needs. presented, the use devident, Other P sta Resident #8's inform Other P stated there	d. That was the computer letary to assist dietary with While on the copy that was of individual bowls was ted she had updated letion. Prior to be updated, was no information individual bowls for Resident			<u>.</u>	
F 431	director of nursing), were informed of the the use of individual	rator, ADON (assistant and corporate consultant a failure of the staff to ensure bowls for all foods to foster ing was implemented 3/4/16	F 43 [,]	1		
S S =D	The facility must em a licensed pharmaci of records of receipt controlled drugs in s accurate reconciliation records are in order	ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all raintained and periodically		F 431 1.) How the Corrective Action was accomplished for those resident found to have been affected. The facility medication rooms, medicarts and medication refrigerators checked for any expired or undated medications, and then they were removed and disposed of per facility protocol by 03/04/16.	ication were	

FORM CMS-2567(02-99) Previous Versions Obsolete

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted

Event IO: ONKI11

Facility IO: VA0021

If continuation sheet Page 91 of 113

DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		•		т,	С
		495252	B. WING		03/04/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	
GOLDEN	I LIVINGCENTER-BA	TTLEFIELD PARK		250 FLANK ROAD	*
	,	()		PETERSBURG, VA 23805	s#
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
F 431	Continued From p	age 91	F4	I 31	
	professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			How the facility will identified residents having the potential affected by the deficient practice.	il to be tice.
				All residents of the facility had to potential to be affected.	he
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in ents under proper temperature it only authorized personnel to keys.		3.) The Following Measures was into place or systematic charmade to ensure that the deficiency practice will not recur.	nges
	permanently affixe controlled drugs lis Comprehensive Drugontrol Act of 1976 abuse, except whe package drug distribution and the control of t	rovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to on the facility uses single unit ibution systems in which the ninimal and a missing dose can		The Field Services Clinical Dir in-service the Director of Nursin monitoring medication storage. Nurses will be in-serviced by 0 the Director of Nursing, or Assi Director of Nursing or RN Super Medication Destruction policy a storage and labeling of medical	ng on Licensed 4/01/16 by stant ervisor on and proper tions.
* .	be readily detected	.		4.) The Facility will monitor if performance to make sure so are sustained.	
	by: Based on observation revidate and store mediate recommendations discharged Reside available for administrations.	NT is not met as evidenced tion, staff interview, and facility iew, the facility staff failed to dications per manufacturer's and failed to ensure nt medications were not distration on two of two units.		Audits will be conducted 3 time week for 3 months by the Director of the Nursing or Assistant Director of the Medication Rooms, Medication Refrigerators and medication densure compliance. These find be brought through the monthly meeting for further review and recommendations.	tor of f Nursing arts to ings will
		of Novolog insulin was dated		5.) Date Corrective Action will completed. Compliance Date is April 4, 20	
	accessed vial of Hi	edication cart 1, an opened and umalog insulin was utilized for ation with no date evident			

CENTERS FOR MEDICARE & MEDICAID SERVICES						<u>MB NO</u>	<u>. 0938</u> -0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495252	B. WING	· 			C / 04/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOLDEN	N LIVINGCENTER-BAT	TLEFIELD PARK		7	250 FLANK ROAD		
				F	PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 431	when the vial was a 3. In the medication cardboard contained comfort kit) was sto with a thick layer of frozen. The Reside died 7/12/15. The findings include During observation carts, the medication observed 3/3/16 began opened and accepted and accep	ccessed; and refrigerator on Unit 2, a r (identified as a hospice red in the freezer, covered ice and the medication was nt was identified as having	F 4	H31			
	opened. LPN A state Resident insulin on I	ed she did not give the her shift so she was not sure the vial, however she said it					
		was a sheet to indicate how re good for once being					
	Guidance was provid	ded at www.novolog.com:					
	"How should I store Do not freeze NovoL if it has been frozen.	.og®. Do not use NovoLog®			i		

SERVICES

DEPARTMENT OF HEALTH AND HUM

PRINTED: 03/15/2016

FORM APPROVED

DEPARTMENT OF HEALTH AND HULL SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
		495252	B. WING				C
	<u>.</u>	1	B. WING			03/	04/2016
	PROVIDER OR SUPPLIE N LIVINGCENTER-B			250	EET ADDRESS, CITY, STATE, ZIP CODE FLANK ROAD FERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 431	Store opener vials in the refriger 8°C). Opened No out of the refriger. Unopened vexpiration date properties in the refriger opened Novaway after 28 day left in them." Observation of the revealed in cart 1 insulin. The vial infrom the emerger vial to indicate where and accessed. LPN D observed 10;48 A.M., the vial opened and accessed in cart 1 insulin. The vial infrom the emerger vial to indicate where and accessed. LPN D observed 10;48 A.M., the vial in	and unopened NovoLog® erator at 36°F to 46°F (2°C to voLog® vials can also be stored ator below 86°F (30°C). Italias may be used until the inted on the label, if they are erator. Italias wollog® vials should be thrown vs., even if they still have insulin The Unit 2 medication carts was a vial of open Humalog andicated it had been obtained ancy supply. No date was on the nen the vial had been opened the vial and stated 3/3/16 at ital should be dated when essed. LPN D stated she had not alin from the vial and was unable in the vial had been accessed. The UMALOG? MALOG vials: The HUMALOG? MALOG vials: The onot use if it has been frozen, the at and out of direct light. Italian be used until the expiration in and label, if they have been		431			

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Event ID: DNKI11

Facility ID: VA0021

)f continuation sheet Page 94 of 113 •

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495252	B. WING			C / 0 4/ 2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		,0-1,2010
GOLDEN	I LIVINGCENTER-BAT	TLEFIELD PARK	1	250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 431	days, if they are sto After HUMALOG via Store opened vials temperature below Keep vials away fro Throw away all ope even if there is insu Guidance the nursin how long insulin wa accessed was askeday meeting. By the guidance was provide The medication refrigera was a cardboard boice. The box was utthe ice, so LPN C to the medications with box appeared to be Resident that had discard after 9/10/18 1 bottle of Morphine substance, a notation discard after 9/10/18 1 bottle of Haldol so a notation on the bo Bag of Biscodyl supafter 7/2/16	and be thrown away after 28 red at room temperature. als have been opened: in the refrigerator or at room 86°F (30°C) for up to 28 days. In heat and out of direct light. In the vials after 28 days of use, lin left in the vial. In left in the end of each of the survey, no ded. In left in the vial. In left in left in left in the left in left in the left in lef	F4	31		
	bag of Ativan tablets	to be discarded after 7/2/16	ı			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

)f continuation sheet Page 95 of 113

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DEPAR	TMENT OF HEALTH	AND HUN SERVICES			C^{*}	PRINT	ED: 03/15/2016
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<i>i</i>		RM APPROVED IO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED
	<u></u>	495252	B. WING	i			C)3/04/2016
NAME OF	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		13/04/2016
GOLDEN	LIVINGCENTER-BAT	TLEFIELD PARK			250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	!X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLDBE	(X5) COMPLETION OATE
F 431	Continued From pag	ge 95	F4	131		<u></u>	
	All of the liquid and frozen.	suppository medication were		;			
	the comfort kit at the or discharge if "som give it to them." LPI	espice provider would discard time of the Resident's death eone thought to get it and N C stated the facility would on if hospice did not take it.					
	Review of the facility Substance Disposal	r's policy entitled "Controlled " included:					
	facility after a resided the order is discontinual. In the facility director of nursing are (or others as allowed 2). By returning Administration (DEA 3). By retaining the DEA; OR 4). By sending the agency/reverse distrilaws, regulation, and Also, review of the position of the process of th	to the Drug Enforcement);OR for destruction by an agent of the appropriate state butor, as directed by state /or the DEA."					
į	Destruction" covered non-controlled medic	destruction of					
	medications should b	ed and non-returnable e removed from their sured until destroyed.					/

Destruction of Medications by Facility

A. All discontinued medication will be

DEPARTMENT OF HEALTH AND HUL IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING				SURVEY PLETED
			7 DOILE			(o .
		495252	B. WING			03/0	04/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	ITLEFIELD PARK		2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	resident's active me stored in a separate or as required by a destroyed by a mar applicable state and E. The facility will pout-dated medication location, to be used expired medications. G. Discontinued medications of the discontinued of the within 90 days of the discontinued of the discontinued of the within 90 days of the within 90 days of the w	edication storage area and elocked area for up to 90 day opplicable law, and then oner in accordance with defederal laws. Colace all discontinued or ones in a designated, secure donly for discontinued and/or st. Colace all discontinued or ones in a designated, secure donly for discontinued and/or st. Colace all discontinued or ones in a designated, secure donly for discontinued and/or st. Colactions and/or out-dated disposed of by the facility defeate the medication was applicable law." Colactions and/or out-dated disposed of by the facility defeate the medication was applicable law." Colactions and/or out-dated disposed of by the facility defeated the medication was applicable law." Colactions and/or out-dated disposed of by the facility defeated the medication was applicable law." Colactions and/or out-dated disposed of by the facility defeated the medication was applicable law." Colactions and/or out-dated disposed of by the facility disposed of by the fac	F	1 31			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 97 of 113

PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUMA ERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD **GOLDEN LIVINGCENTER-BATTLEFIELD PARK** PETERSBURG, VA 23805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 431 Continued From page 97 F 431 "STORAGE: Store at room temperature away from heat. If the room temperature is above 80 degrees F (27 degrees C), then store the medication in the refrigerator. Do not freeze." Ativan tablets at www.drugs.com: "Proper storage of lorazepam: Store lorazepam at room temperature, between 59 and 86 degrees F (15 and 30 degrees C). Store away from heat, moisture, and light. ' The acting administrator, ADON (assistant director of nursing), and corporate consultant

F 441 SS=D

The facility must establish and maintain an Infection Control Program designed to prov

and hospice medications were stored

after discharge, 3/4/16 at 12:15 p.m.

SPREAD, LINENS

Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

were informed of the failure of the staff to ensure, Insulins were dated when opened and accessed, were discarded after the appropriate time frame,

appropriately and discarded in a timely manner

483.65 INFECTION CONTROL, PREVENT

- (a) Infection Control Program
 The facility must establish an Infection Control
 Program under which it ~
- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection

F 441

F 441

 How the Corrective Action was accomplished for those residents found to have been affected.

Resident #3 isolation precautions were discontinued by the physician on 03/02/16. There was no evidence found of any cross contamination.

2.) How the facility will identify other residents having the potential to be affected by the deficient practice.

All residents on isolation precautions have the potential to be affected. There are currently no residents on isolation precautions.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 98 of 113

PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HU **N SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED . A. BUILDING С 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)./ F 441 Continued From page 98 F 441 3.) The Following Measures will be put (1) When the Infection Control Program into place or systematic changes made to ensure that the deficient determines that a resident needs isolation to practice will not recur. prevent the spread of infection, the facility must isolate the resident. Staff will be in-serviced by the Assistant (2) The facility must prohibit employees with a Director of Nursing or RN Nurse communicable disease or infected skin lesions Supervisor on the Isolation contact from direct contact with residents or their food, if precautions-Categories of Transmissiondirect contact will transmit the disease. Based Precautions policy and the (3) The facility must require staff to wash their Handwashing/Hand Hygiene policy by hands after each direct resident contact for which 04/01/16. hand washing is indicated by accepted professional practice. 4.) The Facility will monitor its performance to make sure solutions (c) Linens are sustained. Personnel must handle, store, process and transport linens so as to prevent the spread of Audits of Hand Hygiene and Isolation Precautions will be conducted by the infection. Assistant Director of Nursing Services or RN Nurse Supervisor 3 times per week for 3 months. Findings/Results of audits will be communicated and reviewed in This REQUIREMENT is not met as evidenced the monthly QAPI meeting for further review and recommendations. Based on observation, staff interview, facility documentation review, and clinical record review 5.) Date Corrective Action will be the facility staff failed for 1 resident (Resident #3) completed. of 31 residents in the survey to implement an Compliance Date is April 4, 2016 effective infection control program. 1. For Resident #3, the facility staff failed to implement contact isolation precautions.

FORM CMS-2567(02-99) Previous Versions Obsolete

2. For Resident #3, the facility staff failed to perform proper hand hygiene, and failed to

Resident #3, a 90 year old, was admitted to the facility on 4/11/11. Her diagnoses included colon

implement contact precautions.

The findings included:

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 99 of 113

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE		_	(FORM	D: 03/15/2016 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING	(X3) DAT	TE SURVEY MPLETED
	495252	B. WING	3		C 3 /04/20 16
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	704/2010
GOLDEN LIVINGCENTER-BA	TTLEFIELD PARK		250 FLANK ROAD PETERSBURG, VA 23805		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(OULD BE	(X5) COMPLETION DATE
disease and Methic aureus (MRSA) in the Resident #3's most assessment was a assessment referenceded with a Brief I score of 15 indicating She required extensactivities of daily living On 3/2/16 at 9:05 a observed from the high wheelchair just inside was dressed and with #3 was asked if her that she can feel the painful. On the outside bag with pockets. The protective equipments gowns, red bags, aron the door.	hypertension, degenerative joint cillin-resistant Staphylococcus the right heel wound. It recent Minimum Data Set quarterly assessment with an noce date of 12/8/15. She was interview of Mental Status ng no cognitive impairment, sive assistance with her	F 44	441		

washed and dried both of Resident #3's hands. The woman was not wearing gloves or a gown. She had direct skin to skin contact with Resident #3's hands. A certified nursing assistant (CNA) was in the hallway at the time and was asked to identify the woman with Resident #3. The CNA thought the woman was a volunteer activities staff.

At 9:20 a.m., Registered Nurse B (RN B) was asked which resident in the room was on contact precautions. She stated that only A bed (Resident #3) was on precautions. At 9:25 a.m., a staff member was observed in the room. The

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DNKI11

Facility ID: VA0021

If continuation sheet Page 100 of 113

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

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F 441	to the resident in I precautions). The Resident #3's han doorway at this tin she was a volunte was asked what h stated that she wabed. The woman door and asked th supposed to be us was instructed to staff. On 3/2/16 at 11:00 Licensed Practica what a person need precaution room. sign on the door the nursing staff. LPN gown and gloves in that gloves should hands washed price was expected to footstated that anyone asked if it was required to the door that gloves should hands washed price was expected to footstated that anyone asked if it was required to the door that gloves before exiting she was required to She stated that she gloves before exiting asked two times if	and gloved and providing care B bed (who was not on a woman who had washed ds earlier was standing at the ne. The woman was asked if er. She stated no. The woman er role was at the facility. She as the sister of the resident in B pointed to the blue bag on the is surveyor if she was sing the supplies. The woman ask one of the facility nursing a.m., the unit manager, I Nurse G (LPN G), was asked eded to do to enter a contact LPN G stated that there is a neat directs a person to see the I G would then instruct that needed to be worn. She stated be discarded in the room and or to exiting. When asked who ollow these instructions, LPN G entering the room. When uired that a sign be on the	F	441			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: ONKI11

Facility IO: VA0021

If continuation sheet Page 101 of 113

DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

MAKE OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK SIMMANY STATEMENT OF DEFICIENCIES PREFEX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION) FA41 Continued From page 101 stated no both times the question was asked. Other L did not mention the need to wash her hands before exiting the contact precaution room. The infection control nurse, Registered Nurse A (RN A), was interviewed on 1971/8 at 2.45 p.m. RN A was asked to describe how contact precautions were implemented. She stated that a biue bag with PPE was hung over the door. She stated that the sign should be there. She stated that ablue bag with PPE was hung over the door. She stated that the sign should be there. She stated that the sign was required, RN B stated that the sign was required, RN B stated that the sign should be there. She stated that quown and glove, RN A stated that the sign was required, RN B stated that the sign should gar up. RN A was asked if that included dietary staff, RN A stated that dietary staff do not go in the room. When asked if that included housekeeping staff, RN A stated that the housekeeping should gar up. RN A was asked to explain the importance of contact precautions. She stated that it was to prevent contamination, to prevent one person from getting an infection and taking it to someone else. At the end of day meeting on 3/2/16, the acting Director of Nursing, the acting Administrator, and both corporate nurses were notified that there was no sign on Resident #3's door indicating she was on contact precautions. They were notified that there was no sign on Resident #3's door indicating she was on contact precautions. They were notified that there was no sign on resident without wearing PPE. They were notified that the rousekeeping staff did not know which PPE to wear and did no		TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK (X41) D (X		·	495252	R WING				
GOLDEN LIVINGCENTER-BATTLEFIELD PARK 250 FLANK ROAD PETERSBURG, VA 23805 PROMOBERS PLAN OF CORRECTION (RACH DESTRESSON WISST OF ESCUEDED BY PALL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 101 stated no both times the question was asked. Other L did not mention the need to wash her hands before exiting the contact precaution room. The infection control nurse, Registered Nurse A (RN A), was interviewed on 3/3/16 at 2-45 p.m. RN A was asked to describe how contact precautions were implemented. She stated that a blue bag with PPE was hung over the door. She stated that they was required, RN B stated that gown and gloves should be worn. When asked if the sign should be worn. When asked that anyone taking care of the patient needed to gown and glove. When asked if that included dietary staff, RN A stated that dietary staff on to go in the room. When asked if that included dietary staff, RN A stated that dietary staff on to go in the room. When asked if that included housekeeping staff, RN A stated that the housekeeping staff, RN A stated that the housekeeping staff, RN A was asked to explain the importance of contact precautions. She stated that it was to prevent contamination, to prevent one person from getting an infection and taking it to someone else. At the end of day meeting on 3/2/16, the acting Director of Nursing, the acting Administrator, and both corporate nurses were notified that the was on contact precautions. They were notified that a family member was observed washing Resident #3's hands without wearing PPE. They were notified that a family member was observed washing Resident #3's hands without wearing PPE. They were notified that a CNA was wearing PPE to	NAME OF	PROVIDER OR SUPPLIER		J. W. 10			3/04/2016	
FREEIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) F 441 Continued From page 101 stated no both times the question was asked. Other L did not mention the need to wash her hands before exiting the contact precaution room. The infection control nurse, Registered Nurse A (RN A), was interviewed on 3/3/16 at 2:45 p.m. RN A was asked to describe how contact precautions were implemented. She stated that a blue bag with PPE was hung over the door. She stated that there was usually a sign on the door. When asked if the sign was required, RN B stated that a gown and glove, should be worn. When asked who needed to gown and glove, RN A stated that anyone taking care of the patient needed to gown and glove. When asked if that included visitors, RN A stated that dictary staff, RN A stated that dictary staff do not go in the room. When asked if that included dictary staff, RN A stated that the housekeeping staff, RN A stated that the housekeeping should gear up. RN A was asked to explain the importance of contact precautions. She stated that it was to prevent contamination, to prevent one person from getting an infection and taking it to someone else. At the end of day meeting on 3/2/16, the acting Director of Nursing, the acting Administrator, and both corporate nurses were notified that there was no sign on Resident #3/s door indicating she was on contact precautions. They were notified that a family member was observed washing Resident #3/s hands without wearing PPE. They were notified that the housekeeping staff did not know which PPE to wear and did not know to wash her hands before exiting the room. They were notified that a CNA was wearing PPE to	GOLDEN	I LIVINGCENTER-BAT	TLEFIELD PARK		250 FLANK ROAD	CODE		
stated no both times the question was asked. Other L did not mention the need to wash her hands before exiting the contact precaution room. The infection control nurse, Registered Nurse A (RN A), was interviewed on 3/3/16 at 2/45 p.m. RN A was asked to describe how contact precautions were implemented. She stated that a blue bag with PPE was hung over the door. She stated that there was usually a sign on the door. When asked if the sign was required, RN B stated that the sign should be there. She stated that gown and gloves should be worm. When asked who needed to gown and glove, RNA stated that anyone taking care of the patient needed to gown and glove. When asked if that included visitors, RN A stated no. When asked if that included visitors, RN A stated that dletary staff do not go in the room. When asked if that included housekeeping staff, RN A stated that the housekeeping staff, RN A stated that the housekeeping staff, RN A stated that the housekeeping staff, RN A stated that the housekeeping staff, that included pear up. RN A was asked to explain the importance of contact precautions. She stated that it was to prevent contamination, to prevent one person from getting an infection and taking it to someone else. At the end of day meeting on 3/2/16, the acting Director of Nursing, the acting Administrator, and both corporate nurses were notified that there was no sign on Resident #3's door indicating she was on contact precautions. They were notified that there was observed washing Resident #3's hands without wearing PPE. They were notified that the housekeeping staff did not know which PPE to wear and did not know to wash her hands before exiting the room. They were notified that a CNA was wearing PPE to	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE		
		stated no both times Other L did not men hands before exiting. The infection contro (RN A), was intervier RN A was asked to a precautions were imblue bag with PPE with stated that there was when asked if the stated that the signs that gown and glove asked who needed to stated that anyone to a stated that anyone to a stated that anyone to a stated that anyone to a sked who needed to gown and included visitors, RN that included dietary dietary staff do not good if that included house that the housekeepir asked to explain the precautions. She stated that included house that the housekeepir asked to explain the precautions. She stated that infection and the end of day medical precaution of Nursing, the both corporate nurse was no sign on Residuals on contact precautions and that a family member Resident #3's hands were notified that the know which PPE to wash her hands befowere notified that a Contact precautions.	sthe question was asked. Ition the need to wash her It the contact precaution room. I nurse, Registered Nurse A wed on 3/3/16 at 2:45 p.m. I describe how contact I plemented. She stated that a was hung over the door. She Is usually a sign on the door. I gin was required, RN B I should be there. She stated I should be worn. When I o gown and glove, RN A I aking care of the patient I glove. When asked if that I A stated no. When asked if I staff, RN A stated that I o in the room. When asked I staff, RN A stated that I o in the room. When asked I staff, RN A stated that I have a stated that I was to prevent I went one person from I ind taking it to someone else. I eting on 3/2/16, the acting I he acting Administrator, and I swere notified that there I dent #3's door indicating she I was observed washing I without wearing PPE. They I housekeeping staff did not I wear and did not know to I re exiting the room. They I NA was wearing PPE to	F4				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 102 of 113

DEPA	RTMENT OF HEALTH	AND HUM SERVICES			ϵ^{-1}	RINTE	D: 03/15/2016
		& MEDICA U SERVICES	,			PORI SMB NC	M APP R OVED 0. 0938-0391
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
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F 44 ⁻	Pag	on regarding Resident #3's	F4	 141			
	Transmission-Based Contact precautions "1) Infections with m (determined on a ca	ed "Isolation-Categories of I Precautions" was reviewed. were addressed on page 3. ulti-drug resistant organisms se by case basis)" was listed of infections requiring					
	handwashing "1) In a outlined under Stand (clean, non-sterile) w 2) While caring for a having contact with it example, fecal mater Remove gloves befor perform hand hygien and washing hands,	rial and wound drainage). 3) re leaving the room and e. 4) After removing gloves do not touch potentially nmental surfaces or items in					
	a disposable gown up Precautions room or 2. On 3/1/16 at 4:15 I made of the medicati Nurse B was observe Tears to Resident #3' contact precautions for Staphylococcus Aurel LPN B was not wearing providing care for Resident	ollowing about gowns "Wear con entering the Contact cubicle." J.M., an observation was on pass. Licensed Practical ed administering Artificial s eyes. Resident #3 was on or Methicillin Resistant us (an infection) in her foot. In a disposable gown while sident #3. She wore gloves, she washed her hands				,	

FORM CMS-2567(02-99) Previous Versions Obsolete

On 3/1/16 at 4:20 P.M., an interview was

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 103 of 113

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		E SURVEY PLETED
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(V4) ID	. SIMMADV STA	TEMENT OF DEFICIENCIES		PETERSBURG, VA 23805		*
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F 441			F 4	141		
į	importance of wear why she didn't wear MRSA in her heel. S wound itself, I didn't important to preven Handwashing shoul	I B. When asked about the ing a disposable gown, and one, LPN B stated, "She has since I'm not messing with the put it on. Handwashing is t infection from me or them. d be for 30 seconds. I use the 't know why I didn't use the of nerves."				·
F 456 SS=D	documentation, revery Hygiene Policy date facility considers had means to prevent the hands with soap and situations: After considerations caused by shigella and C. difficient with soap and rub the toall surfaces for a stronger under a mode at a comfortable term. On 3/2/16 at 4:00 P. Nursing (Administrating), No further if 483.70(c)(2) ESSEN OPERATING COND. The facility must ma mechanical, electrical equipment in safe of	M. the facility Director of tion B) was notified of the nformation was received. ITIAL EQUIPMENT, SAFE ITION intain all essential al, and patient care perating condition.	F 4	F 456 1.) How the Corrective Action waccomplished for those reside found to have been affected. The Crash Cart on Unit 1 had the Oxygen tank replaced with a full tank and the Unit 2 Crash Cart has suction catheters placed on it on 03/03/16. Resident #1 feeding pump pole we cleaned on 03/03/16 2.) How the facility will identify the residents having the potential to affected by the deficient practice. All residents had the potential to be affected.	expend d as other be	
I	This REQUIREMEN by:	T is not met as evidenced		affected affected	,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 104 of 113

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B. WING	, j	ĺ	C	
		ITLEFIELD PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	1 03/	/04/2016	
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Badoo ens fun two 1. the have 2. If ens and uni 3. If ma The 1. the have On was carripra the revi the was night "No the On cart	cumentation revisure essential eductional for Resident and cart. On we suction cathet For Resident #1, sure her gastrost diffailed to ensure its were clean; For Resident # 2 intain a clean tube findings include On unit One, the crash cart. On we suction cathet a 3/3/16 at 3:25 P is observed. The twas determined to cathet was determined to cathet a cart. The iewed, which shows a sked if the crash cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed, which shows a sked if the crash tor during the control of the cart. The iewed is a sked if the crash tor during the cart. The iewed is a sked if the crash tor during the control of the cart. The iewed is a sked if the crash tor during the cart.	tion, staff interview and facility ew, the facility staff failed to pulpment was clean and lent #1 and Resident #2, for its and two crash carts. It oxygen tank was empty on Unit two, the crash cart did not ers available. Ithe facility staff failed to omy pump pole was clean emedication carts on both To the facility staff failed to be feeding pole. Ithe facility staff failed to one feeding pole. The facility staff failed to be feeding pole. The facility staff failed to be feeding pole.	F	3.) The Following Measures will Into place or systematic changes made to ensure that the deficient practice will not recur. Housekeeping will be in-serviced by Executive Director or Director of Nursing or Nurse Supervisor by 04/01/16 on the cleaning of poles and other equipment and surfaces in resident rooms. The Field Services Clinical Director educate the Director of Nursing Serviced by Director of Nursing or Assistant Director of Nursing or Assistant Director of Nursing or Assistant Director of Nursing or Assistant Director of Nursing or RN Nurse Supervisor on replacing item are not found on the crash carts from checklist. 4.) The Facility will monitor its performance to make sure solution are sustained. Audits of the crash carts will be conducted by the Director of Nursing or Nurse Supervisors 3 times per week for 3 months to ensure all equipment and items are present. Results of the audit will be presented in QAPI for discuss and follow up/action. Audits of rooms feeding pump poles will be checked the non clinical round 3 times per we for 3 months by the Executive Direct Director of Nursing or RN Nurse Supervisor. Findings of the audits will be discuss and reviewed in the monthly QAPI for follow up and recommendations. 5.) Date Corrective Action will be completed. Compliance Date is April 4, 2016	/ the rsing RN e ent will vices are on in- in the rsicon side with via ek or or ctor ed		

DEPARTMENT OF HEALTH AND HUN PRINTED: 03/15/2016 1 SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED С 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 456 Continued From page 105 F 456 crash cart check list was observed, which showed the nurse had signed off suction catheters were on the crash cart. On 3/3/16 at 4:15 PM, the Administrator and nurse consultant were notified of above findings. 2. For Resident #1, the facility staff failed to ensure her gastrostomy pump pole was clean and failed to ensure medication carts on both units were clean. Resident #1, a female, was admitted to the facility 6/13/13. Her diagnoses included sacral pressure ulcer, aphasia, contracture, Alzheimer's dementia, and hypertension. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/28/15 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring total assistance of one to two staff members to perform her activities of daily living. She was coded as receiving all nutrition and hydration by a gastrostomy tube. A gastrostomy tube is a flexible tube surgically inserted though the abdominal wall into the stomach. The tube is utilized to administer hydration, nutrition, and medications to Residents RECEIVED who are unable to swallow. Resident #1 was observed 3/1/16 during initial APR 0 1 2016 tour of the facility, 3/1/16 at 5:06 p.m., 3/2/16 at 8 a.m., 3/2/16 at 8:45 a.m., and 3/3/16 at 8:02 a.m.

At all observations, Resident #1 was lying on her back or side with the head of her bed elevated. Her eyes were closed and her gastrostomy tube

VDH/OLC

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES			(FOR	D: 03/15/2016 MAPP R OVE)
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	D. 0938-039° TE SURVEY MPLETED	1
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	was infusing at 35 c Jevity 1.5 was infusi pump. At all of the o pole, holding the pur light brown substance substance was also stand. When interviewed, F it was housekeeping pump poles clean, 3 During observation o carts, 3/3/16 beginni medication carts on tops of both carts we debris. The sides ar dried droplet substan areas that held the p cups. On Unit 2, the medic beginning at 10:48 of the same white debri	c (cubic centimeters) an hour. Ing through a gastrostomy observations, the base of the mp, was covered with dried ce. Some of the dried on the floor under the pole can be floor under the can be floor under the floo	F	156				
	p.m., she was uncert medication carts sho she thought the nurse prior to beginning the The acting administratof nursing), and corportinformed of the failure Resident #1's gastrosmedication carts on upon unit 2 were clean,	ain as to when the uld be cleaned. She did say es should clean the carts ir medication pass. ator, ADON (acting director prate consultant were of the staff to ensure stomy pump pole, the unit 1, and medication cart 2			RECEIVE APR 0 1 2016 VDH/OLC	į		

maintain a clean tube feeding pole.

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) O	(X3) OATE SURVEY COMPLETEO	
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	Resident # 27 was to the facility on 2/1 but not limited to, T Stroke, Hemiplegia Gastrostomy, Majo Episode, Hypertens Disease (GERD), a The most recent M quarterly assessme Reference Date (Al coded Resident # 2 moderately impaire assistance of one to activities of daily liv bowel and bladder. On 3/3/2016 at 11:5 the pole holding the dried yellowish debit of the dried yellowish debit on Resident # 2 window and her hus surveyor at the time N) was in the room. Spoke to Other N ar Other N was "good on 3/3/2016 at 12 m conducted with Houstated "out of respected the rooms whome back when we come back when we	a 60 year old female admitted 18/2012 with the diagnoses of, ype 1 Diabetes Mellitus, and Hemiparesis, Aphasia, or Depressive Disorder, Single sion, Gastroesophageal Reflux and Cataract. inimum Data Set (MDS) was a cent with an Assessment RD) of 1/19/2016. The MDS 27 with cognitive status as did, required extensive to two staff members with ing and always incontinent of an AM, observed the base of tube feeding was soiled with ris in three areas. 50 AM, observed the base of the enter the room of Resident # ea around the bed by the shand was talking to the enter the room of Resident # ea around the bed by the shand was talking to the enter the room of Resident # 27's husband and stated to the surveyor that and does a good job." 50 AM, observed the base of the enter the room of Resident # 27's husband and stated to the surveyor that and does a good job." 50 AM, observed the base of the enter the room of Resident # 27's husband and stated to the surveyor that and does a good job." 50 AM, observed the base of the enter the room of Resident # 27's husband and stated to the surveyor that and does a good job."	F	456	RECEIVE APR 0 1 2016 VDH/OLC		
	On 3/3/2016 at 2:30	PM Other N was observed					

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICA SERVICES			(FORI	D: 03/15/2016 MAPPROVED
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NAME OF	PROVIDER OR SUPPLIER		·	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	03	3/04/2016
GOLDE	N LIVINGCENTER-BAT	TLEFIELD PARK			250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT	DRE	(X5) COMPLETION DATE
F 456	cleaning Resident # the resident's husba plastic cap that fit or tissue were remove bed. An interview was co 3/3/2016 at 3 PM. F room with the survey the tube feeding pola and stated she was cleaned. RN B state the nursing departm poles. The administrator ar were informed of the feeding pole during t 3/3/2016. No dirt or debris was room on 3/4/2016 at pole was observed to debris. On 3/4/2016 at 8:30 conducted with RN E nursing staff change stated she instructed any spills of tube feed An interview was cor AM with the Houseke stated "terminal clear rooms on a schedule J stated that routine of the rooms.	ge 108 27's side of the room while and was out of the room. One in tube feeding tube and one in tube feeding tube and one in tube feeding tube and one in tube feeding tube and one in tube feeding tube and one in tube feeding when the tube did it is dirty going to make sure it was it was it was the responsibility of ent to clean the tube feeding in the clean of day debriefing on the clean of day debriefing on the clean and without it was the responsibility of ent to clean the tube feeding on the clean and without it was the responsibility of ent to clean and without it was the responsibility of ent to clean and without it was the feeding on the clean and without it was a who stated she had the the tube feeding pole. RN B is the nursing staff to clean ding at the time of the spill. Inducted on 3/4/2016 at 10:30 deping Director (Other J) who may be done in all of the control of the cleaning is done daily in all of the cleaning the cleaning the cleaning the clean	F	456		IVED 1 2016 /OLC	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED -	
	•	495252	B. WING	l			C /04/2016
•	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805	1 03/	<i>₩</i>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY),/	BE	(X5) COMPLETION DATE
F 456	Housekeeping polic Cleaning" dated 1/ should follow a 5 sto 1)empty trash, 2) ho	by on "Daily Patient Room 1/2000 which stated the staff ep room cleaning method: orizontal dusting, 3)spot clean, and 5) damp mop floor.	F 4	156	F 514 1.) How the Corrective Action was accomplished for those residents found to have been affected. Resident # 12 face sheet was verified and corrected on 03/02/16 2.) How the facility will identify other residents having the potential to be	ег	
F 514 SS=D	LE The facility must ma resident in accordar standards and pract	ETE/ACCURATE/ACCESSIB aintain clinical records on each ace with accepted professional ices that are complete; ited; readily accessible; and	F 5	514	affected by the deficient practice. The Admission Director and or Admissions Assistant or Medical Recivill conduct a audit of current resident face sheets to ensure that there are nowith inaccurate Sexual Offense information by 04/01/16 3.) The Following Measures will be into place or systematic changes made to ensure that the deficient practice will not recur.	t one	
	information to identification resident's assessment services provided; the	ning conducted by the State;			Admissions, Social Services, Medica Records will be in-serviced by the Executive Director on ensuring the accuracy of information on the Reside face sheets by 04/01/16 which will include Sex Offender status. 4.) The Facility will monitor its		
	by: Based on observative record review, the factoriate medical record review.				performance to make sure solution are sustained. Residents face sheet will be reviewed accuracy upon admission and quarter by the Social Worker, or Social Work Assistant, or Admissions Director or Admissions Assistant and findings will	d for dy er	
	information on the fa a Sexual Offense, th	he facility staff had inaccurate ace sheet. Under Convicted of the facility answered "yes" and of conviction of a sexual # 12.			reported in QAPI monthly for review a action steps. 5.) Date Corrective Action will be completed. April 4, 2016	ind . ;	

DEPARTMENT OF HEALTH AND HUM. 3ERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						
		495252	B. WING			C 03/04/20 16		
	PROVIDER OR SUPPLIER	TLEFIELD PARK	·	250	REET ADDRESS, CITY, STATE, ZIP CODE D FLANK ROAD TERSBURG, VA 23805	1 00	0-1/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 514	Continued From pa	ge 110	F 5	514				
	admitted to the facilincluded but not lim Morbid Obesity, Ma Anxiety, Hypertensi Obstruction.	year old female, was lity 12/8/2014. Her diagnoses ited to Psychosis, Diabetes, jor Depressive Disorder, on and history of Intestinal			·			
	2/1/2016 was coded Resident # 12's cog make every day life was not coded. Da areas of Section C Mental Status" thro Daily Decision Maki coded as needing e one to two staff men of daily living with the eating, Resident # 1 limited assistance. I always incontinent of Resident #12 was of speak, understand, Review of the clinical	st recent MDS with an ARD of d as a quarterly assessment. Initive status (her ability to decisions and memory ability) shes were entered in the 100 "Should Brief Interview for ugh C 1000" Cognitive Skill for ing." Resident # 12 was extensive to total assistance of mbers to perform her activities he exception of eating. For 12 was coded as needing only Resident #12 was coded as of bowel and bladder. Toded as being able to hear, and be understood.			;			
;	and located in the firevealed under "Otr question Convicted answered as "yes". 3/2/3016 at 4 PM, a with Unit Manager (Sheet printed on 10/16/2015 ont of the clinical record her Information" that the of a sexual offense was n interview was conducted LPN G Licensed Practical d she did not think Resident#						

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE	
495252 B. WING 03/04/	4/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	+/2010
GOLDEN LIVINGCENTER-BATTLEFIELD PARK 250 FLANK ROAD PETERSBURG, VA 23805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 514 Continued From page 111 12 was a convicted sex offender. LPN G reviewed the face sheet and stated she was going to double check with the Social Services Director and Admissions Coordinator. LPN G stated she had not noticed the "yes" answer under convicted of a sexual offense but thought it was a mistake. LPN G stated she usually used the face sheet to look for the demographics, physicians, pharmacy and responsible party and insurance information. Interview was conducted with Social Services Director (Other D) on 3/2/2016 at 4:30 PM who stated she was told by the Unit Manager (LPN G-Licensed Practical Nurse G) that the face sheet showed "yes" for Sexual Offender status. Other D stated she asked the Admission Coordinator (Other F) to rerun the Sex Offender Registry for Resident # 12 was not listed as a known sex offender. 3/2/2016 at 4:35 PM, interview conducted with Admission Coordinator (Other F) who stated she ran the Sex Offender Registry Search and it showed that Resident # 12 was not on the list. Other F stated the wrong button was clicked when the face sheet was typed because Resident # 12 was not a convicted sex offender. Other F stated she was going to run a corrected copy of the face sheet. The Administrator, Director of Nursing and Corporate Consultant (Admin C) were informed of the answer of "yes" for Convicted of a sexual offense on the face sheet of Resident # 12 during the end of day debriefing on 3/2/2016 at approximately 5 PM.	

		AND HUMA'' SERVICES		(PRINTED: 03/15/ FORM APPRO OMB NO. 0938-0	VED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVE COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		_
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F 514	Continued From pa	-	F 51	4		
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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495252	B. WING			03/	04/2016
	ROVIDER OR SUPPLIER LIVINGCENTER-BAT	TLEFIELD PARK	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	N BE RIATE	(X5) COMPLETION DATE	
	shift, 1/24/16 day shift, 2/8/16 day shift, 2/8/16 day shift, 2/4/16 day shift, 1/23/16 day shift, 2/4/16 day shift, 2/4/16 day shift, 1/29/16 day shift, 2/8/16 16 day shift, 2/8/16/16/16/16/16/16/16/16/16/16/16/16/16/	evening shift, 1/23/16 day nift, 1/29/16 day shift, 2/4/16 y shift v shift: 1/5/16 evening shift, 1/24/16 day shift, 1/29/16 day	F3	809			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DNKI11

Facility ID: VA0021

If continuation sheet Page 56 of 113



DEPARTMENT OF HEALTH AND HULE I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 .	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495252	B. WING_		02	C 3/04/2016	
	ROVIDER OR SUPPLIER	TTLEFIELD PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805				
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F 309	medication dose re the resident's MAR record) directly after the end of each me administering the modern to ensure necessary and documented. Individual who admoff-duty without first of any medications. When interviewed, stated 3/2/16 at 3:1 treatments followed medications and shaving been admin documentation for the treatment nurse treatments in the fadocumenting them, question, the treatment in the fadocumenting them, question, the treatment of the stated she did not know been administered. Guidance for nursing administration of me "Fundamentals of Netter-Perry, page, such as the America Nursing: Scope an Practice (2004) approach in the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the state of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights medication errors of the six rights and six rights medication errors of the six rights medication errors of the six rights and six righ	ual who administers the cords the administration on (medication administration or the medication is given. At idication pass, the person nedications reviews the MAR y doses were administered in no case should the inister the medications report trecording the administration. RN (registered nurse) B 5 p.m., the administration of I the same standards as would be documented as istered. After reviewing the treatments, RN B stated is traditionally did all the initiationally did all the initiation of I the same standards in the treatments. RN B stated is traditionally did all the initiation of I the said on the days in ment nurse had to pass at each nurse would have on their treatments. RN B standards for the initiation of I the treatments and in the days in question. In grandards for the edication is provided by Jursing, 7th Edition, 705: Professional standards, an Nurses Association's distandards of Nursing only to the activity of medication prevent medication errors, of medications. Many an be linked, in some way, to	F 30	09			
	an inconsistency in	adhering to the six rights of					

DEPARTMENT OF HEALTH AND HUN. ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C		
	495252	B. WING			1	4/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BAT	TLEFIELD PARK		25	REET ADDRESS, CITY, STATE, ZIP CODE 0 FLANK ROAD ETERSBURG, VA 23805		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
medication adminis 1. The right me 2. The right do 3. The right do 4. The right ro 5. The right tin 6. The right do The acting adminis director of nursing) were informed of the administer the treat #1 per physician's 3. For Resident #8 ensure treatments by the physician. Resident #8, a femthe facility 9/10/08 hospitalization 8/4/ hypothyroidism, dedisorder, unspecifichly pertension, arter disease, and gastro Resident #8's mos set) with an ARD (and 11/24/15 was coded as memory deficits are assistance of one activities of daily live.	stration. The six rights of stration include the following: edication issement utene edication." trator, ADON (assistant, and corporate consultant ine failure of the staff to the staff to the staff to the failure of the staff to the failure of the staff to the failure of the staff to the failure of the staff to the failure of the staff to the failure of the staff to the failure of the staff to the failure of the staff to the failure of the staff failed to were administered as ordered ale, was initially admitted to and readmitted after a 10. Her diagnoses included the failure of the f		309			

FORM CMS-2567(02-99) Previous Versions Obsolele

Event ID: DNKI11

Facility ID: VA0021

If continuation sheet Page 58 of 113

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COM	IPLETED
		495252	B. WING				
	PROVIDER OR SUPPLIER	TTLEFIELD PARK	1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD PETERSBURG, VA 23805	RECTION (XE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Chair alarm every con day shift, 2/8/16 assist side rails on and mobility every selected alarm: 2/4/16 2/28/16 day shift. 2/2/8/16 day shift. 2/8/16 day shift. 2/8/16 day shift, 2/8/16 Pads to arms of whom day shift, 2/8/16 day	day and evening shift: 2/4/16 day shift, 2/28/16 day shift bed to assist with positioning shift: 2/4/16 on day shift,	F				
	documentation for the treatment nurse	istered. After reviewing the the treatments, RN B stated traditionally did all the cility and was responsible for					

	TMENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES			,	FORM	: 03/15/2016 APPROVED : 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY MPLETED
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	PROVIDER OR SUPPLIER I LIVINGCENTER-BAT	TLEFIELD PARK		;	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE
F 309	documenting them. question, the treatm medications and that been responsible for she did not know if it done, however she administered on the administered on the The acting administ consultant were infort to administer the tree #8 per physician's of 4. For Resident #17 administer medication ordered by the physical Resident #17, a fem the facility 4/1/10 and hospitalization 4/29/seizures, type II diated depression, constipated peripheral vascular or reflux disease, and I Resident #17's most 2/18/16 was coded at Resident #17 was codeficits and was abled decisions. She was extensive assistance perform her activities exception of bathing as requiring total assistance.	RN B said on the days in tent nurse had to pass at each nurse would have in the treatments. RN B stated the treatments had been did not think they had been days in question. Tator, ADON, and corporate armed of the failure of the staff atments indicated to Resident riders, 3/4/16 at 12:15 p.m. To the facility staff failed to cons and treatments as ician. Tale, was initially admitted to did readmitted after a did. Her diagnoses included bettes mellitus, cataract, ation, hyperlipidemia, disease, gastroesophageal hypertension. The recent MDS with an ARD of as a quarterly assessment, and as having no memory at the make her own daily life coded as needing limited to be of one staff member to be of daily living with the code of one staff member. The recent make her own daily life coded as needing limited to be of one staff member to so of daily living with the code of one staff member. The recent make her own daily life coded as needing limited to be of one staff member to so of daily living with the code of one staff member.	F:	309	9		

PRINTED: 03/15/2016 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C 495252 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD GOLDEN LIVINGCENTER-BATTLEFIELD PARK PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 309 Continued From page 60 F 309 Monitor blood pressure and pulse q (every) week: No pulses were obtained for the following weeks 1/7/16, 1/14/16, 1/21/16, 1/28/16, 2/4/16, 2/11/16, 2/18/16, and 2/25/16 Tylenol 8 hour extended release 650 1 tablet every 8 hours: 2/21/16 at 2 p.m., 2/26/16 at 2 p.m. Gold Bond cream every shift to abdominal folds: 2/14/15 on evening and night shift Sure prep to first metatarsal on right foot every shift: 2/1/4/16 on evening and night shift When interviewed, RN B stated 3/3/16 at 2:18 p.m., the nurse that entered the order for blood pressure and pulse to be obtained weekly in the computer, did not put the order in correctly. No area was entered for the pulse to be documented. therefore the nurse did not obtain the pulse. RN B was unable to determine if the medications and treatments had been administered or were not administered. Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "Administration 2). Medications are administered in accordance with written orders of the prescriber.

Documentation:

3). The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST				СОМ	E SURVEY PLETED
		495252	B. WING					l	04/2016
	PROVIDER OR SUPPLIER	ITLEFIELD PARK		250 FLAN		Y, STATE, ZIP (CODE	1 00/	0-1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		EACH CORR	R'S PLAN OF CO ECTIVE ACTION ENCED TO THE DEFICIENCY)	N SHOULD APPROPE	BE	(X5) COMPLETION DATE
F 309	on each MAR are of signature in the spatial applicable signature. The acting administ director of nursing, informed of the failuredications and traceident #17 per phosphare 12:15 p.m. 5. For Resident #2 administer medical ordered by the physical Resident #20, a fer facility 11/1/13. Here parkinson's, anxiet pulmonary disease cerebral pseudo so dementia, unspecificate delusions, osteoartifailure. Resident #20's mosphare 12/1/15 was coded Resident #20 was coded Resident #20 was addecisions. Resider extensive to total as members to perform with the exception of #20 was coded as a of one staff members review of Resident Review of Review of Resident Review of Revi	trator, ADON (assistant and corporate consultant were use of the staff to administer eatments as indicated to hysician's orders, 3/4/16 at O, the facility staff failed to tions and treatments as sician. Inale, was admitted to the rediagnoses included y, chronic obstructive anemia, hyperlipidemia, lerosis, epidemic vertigo, ied psychosis, paranoid hritis, and congestive heart at recent MDS with an ARD of as a quarterly assessment, coded as having no memory le to make her own daily life at #20 was coded as needing esistance of one to two staff in her activities of daily living of eating. For eating, Resident requiring standby assistance or . ##20's clinical record revealed owing medications and	F3	09					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DNKI11

Facility ID: VA0021

DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		495252	B. WING			C 03/04/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER-BA			STREET ADDRESS, CITY, STATE, ZIP CODI 250 FLANK ROAD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Greers goo apply t as needed: 1/15/1 night shift, 2/14/16 MA 65 air mattress	o buttocks q (every) shift and 6 on evening shift, 1/31/16 on evening and night shift s every shift: 1/15/16 on 1/16 night shift, 2/14/16 on	F3	309			
	Monitor sutures to shift, 1/31/6 night shift FerrouSul tablet 32	right thigh: 1/15/16 on evening shift, 2/14/16 on evening and 25 mg (milligram) by mouth 2/21/16 1 p.m.					
	A valid physician's medications and tr of the clinical reco Resident was out o	order was evident for all the eatments in question. Review rd revealed no evidence of the facility or had refused the tments in question.				,	
	presented to deter	the survey, no evidence was mine if the medications and ot administered or if they were not documented.					
	consultant were in to administer medi	strator, ADON, and corporate formed of the failure of the staff cations and treatments as ent #20 per physician's orders, n.					
		28, the facility staff failed to ents as ordered by the					
	facility 2/4/13. Her	male, was admitted to the diagnoses included legally all fibrillation, type II diabetes					

DEPARTMENT OF HEALTH AND HUMA. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION	сом	E SURVEY PLETED
		495252	B. WING				04/2016
	PROVIDER OR SUPPLIER	ITLEFIELD PARK		2	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805	1 00	0-1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	mellitus, chronic rei pulmonary disease vascular disease, o transient ischemic at Resident #28's mos set) with an ARD (a 1/6/16 was coded at Resident #28 was odeficits and was abdecisions. Resider minimal to stand by member with her ac exception of bathin as requiring total as Review of Resident no evidence the folloadministered per plus Barrier cream every 1/29/16 A thorough review on indication that Retreatment or was no question. A valid physician's of treatment. The acting administiconsultant were information as consultant were informatical as the pulmon and the	nal failure, chronic obstructive, hyperlipidemia, peripheral ongestive heart failure, attack, and hypertension. St recent MDS (minimum data assessment reference date) of as a quarterly assessment. Coded as having no memory le to make her own daily life at #28 was coded as needing assistance of one staff ctivities of daily living with the g. For bathing, she was coded assistance of one staff member. If #28's clinical record revealed lowing treatments were hysician's orders: If day: 1/23/16, 1/24/16, If the clinical record revealed esident #28 refused the ot at the facility on the days in order was evident for the trator, ADON, and corporate ormed of the failure of the staff or cream daily on 1/23, 1/24.	F3				
	7. For Resident #4 medications, includ	, the facility failed to document ing an antibiotic.					

DEPARTMENT OF HEALTH AND HUMA **JERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	FIPLE CONSTRUCTION NG	COV	E SURVEY MPLETED
		495252	B. WING			04/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK				STREET ADDRESS, CITY, STATE, 2 250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 Resident #4 was admitted to the facility on 4/25/07. Diagnoses included dementia, pneumonia, schizophrenia and diabetes. The most recent MDS (minimum data set) dated 2/3/16 did not code the resident's BIMS (brief interview of mental status) score nor had his cognitive status been assessed, but contained only dashes. The previous MDS had coded the BIMS score as "7" out of a possible 15 or moderate cognitive impairment. The MDS coded the resident as requiring total assistance of one staff member for ADL's (activities of daily living) such as bed mobility and transferring. Review of the MAR (medication administration record) for February 2016 revealed several medications not documented as given. These are the omissions: 2/6/16: 2:00 PM- Humalog 3 units subcutaneously every 8 hrs 2/21/16: 12:00 PM- Clindamycin (antibiotic)150 mg (milligrams) every 6 hours for pneumonia 2/21/16: 1:00 PM- Ferrous sulfate 325 mg (iron supplement) one tablet three times daily 2/21/16: 1:00 PM- Ferrous sulfate 7.5 cc (cubic centimeters) three times daily 2/21/16: 1:00 PM- Seroquel (antipsychotic) 25 mg every 8 hours 2/6/16: 1:00 PM- Seroquel 50 mg three times daily			09		
·	(director of nursing	PM, the Administrator and DON g) were notified of above N stated, "The medications when given."				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DNKI t1

Facility ID: VA0021

If continuation sheet Page 65 of 113

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495252	B. WING			C 03/04/2016		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-BATTLEFIELD PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION OATE		
F 309	Resident # 2 was an 10/7/13 and readmin 1/14/16. Her diagnoto, diabetes, anemia disease, peripheral aphasia (a commur) The most recent Minguarterly assessment Reference Date (AF coded Resident # 2 severely impaired; ractivities of daily livining incontinent of bowe catheter for bladder #2 was coded as refeeding tube and foulcer. The MDS deulcer as follows, "Fexposed bone, tendeschar may be preswound bed.) Review of Resident no evidence that the administered: "Medihoney Wound Right Middle Shin to open area. Clean w	, the facility staff failed to as ordered by the physician. dmitted to the facility on itted after a hospitalization on oses included, but not limited a, hypertension, heart vascular disease, and	F 3	09				
	1/23, 1/24, 1/29/16. Santyl Ointment 250	O unit/gm (gram), Apply to ery day shift for sacral wound.			•			

DEPARTMENT OF HEALTH AND HUMÁ. CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURV COMPLETE	
		495252	B. WING			1	C 04/2016
	OVIDER OR SUPPLIER	TLEFIELD PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805			1 03/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
C1/B for H1/VIII Atr C wd T pi Coord for 9 cl in	arrier Cream to bill or excoriation- 1/5/ leel lift boot to left 1/5/16 evening shift for Absorbent Dr 1/5/16 evening shift for Absorbent Dr 1/5/16 evening shift for Absorbent Dr 1/5/16 evening shift for Absorbent Dr 1/5/16 evening shift for Absorbent Dr 1/5/16, evening shift for Absorbent Dr 1/5/16, evening shift for Absorbent for Abso	lateral buttocks q (every) shift 16, evening shift. foot every shift for prevention - i. every shift for pressure ulcer - i. essing to right middle shin - i. ous every shift for pressure ing shift." order was evident for the ion. i.m., the director of nursing a treatments that were not ving been administered.		309			

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Event ID: DNKI11

Facility ID: VA0021

DEPARTMENT OF HEALTH AND HUMA 3ERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495252	B. WING				C 04/2016
	PROVIDER OR SUPPLIE	ATTLEFIELD PARK		STREET ADDRESS, CITY, STATE, 250 FLANK ROAD PETERSBURG, VA 23805	ZIP CODE	1 03/	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION OATE
F 309	Resident # 16 wa admitted to the fareadmitted on 1/1 but not limited to, Gastroesophagea Vascular Disease Dysphagia, End S Gastrointestinal F The most recent If quarterly assessm Reference Date (a coded Resident # Mental Status (Blisevere cognitive is assistance of one daily living and alwoladder. Clinical record reval/2/2016. Review of the Feb Administration Review of the Feb Administration Review of the Phyby the physician of "Accu-Chek Active application in vitro related to Type 2 I complications" or Review of the Nur	s an 80 year old female cility on 7/19/2015 and 3/2016 with the diagnoses of, Congestive Heart Failure, al Reflux Disease, Peripheral, Hypertension, Diabetes, Stage Renal Disease, Anxiety, Ilemorrhage, and Dyspnea. Minimum Data Set (MDS) was a nent with an Assessment ARD) of 12/30/2015. The MDS 16 with a Brief Interview for MS) of 4 out of 15 indicating impairment; required extensive staff member with activities of ways incontinent of bowel and view was conducted on view was conducted on view of blood sugar results sugar of 562 on 2/25/2016 at 9 visicians Order Summary signed in 2/9/2016 showed an order for extension of Strip (Glucose Blood) 1 before meals and at bedtime Diabetes Mellitus without der date 1/13/2016. Ses Notes revealed no physician being notified of	F	309			

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Event ID: DNKI11

Facility ID: VA0021

DEPARTMENT OF HEALTH AND HUMA **3ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

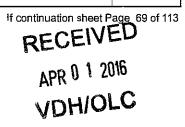
PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		495252	B. WING			l	04/ 2 016		
NAME OF PROVIDER OR S				STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805					
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
Administraticonsultanticonsultanticonsultanticonducter for Adebettime. The would check thought it will notified if bigreater that the greater that the conducted (Licensed Filter were no part Accu-Check nurse should be showed two sh	end of corporation of 562 ccu-Chene Corporation 400. 6 at 10 with the crast that cood such 400. 6 at 10 with the crast camete blood side have call in the call i	-		309					

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Event ID: DNKI11

Facility ID: VA0021



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495252	B. WING		₩ ,	1	C 04/2 01 6
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	<u>04120 10</u>
GOLDEN LIVINGCENTER-BATTLEFIELD PARK			250 FLANK ROAD PETERSBURG, VA 23805				* '
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY),/) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 69	f F3	309			
	copy of the facility's Guideline, Version of Monitoring/Compliant elements are in placed emonstrate satisfaction. Residents with a diagorder for Blood Gludoctor) notification gel is used for hypoton page 6 of 7, Act Resident under cap "inform physician as one occurrence"	actory compliance with the agnosis of Diabetes have an cose monitoring, MD (medical parameters in place, Glucose			RECEIVED APR 0 1 2016 VDH/OLC		
F 313 SS=D	To ensure that resident and assistive device hearing abilities, the assist the resident iby arranging for training the statement is the statement in the statement in the statement is the statement in the statement in the statement is the statement in the statem	ents receive proper treatment es to maintain vision and e facility must, if necessary, n making appointments, and asportation to and from the	F3	313	accomplished for those residents found to have been affected. Resident # 4 had new glasses order and they were received and given to resident on 03/22/16.	red the	
	treatment of vision of office of a profession provision of vision of this REQUIREMENT by: Based on observat	er specializing in the or hearing impairment or the mal specializing in the or hearing assistive devices. NT is not met as evidenced ion, staff interview and clinical acility staff failed to ensure			2.) How the facility will identify oth residents having the potential to be affected by the deficient practice. Residents with assistive vision device have the ability to be affected and an audit will be conducted by the Social Worker or Social Worker Assistant of those residents to ensure that their assistive vision devices are available them. Audit will be conducted by 04/01/16.	es	